

PASRR

Part I: Overview

OMNIBUS RECONCILIATION ACT OF 1987 (OBRA) Pre-Admission Screening and Resident Review (PASRR)

Part I: Overview

INTRODUCTION

The Omnibus Reconciliation Act of 1987 (OBRA) and P.L. 100-203, Section 4211(c)(7), and OBRA 1990 contain provisions with major implications for persons with mental illness or mental retardation/related condition **[who are applying or residing in a nursing facility]**. The provisions were designed to eliminate the practice of inappropriately placing persons with mental illness, mental retardation, and related conditions in Medicaid certified nursing facilities. This Act mandates the Department for Mental Health and Mental Retardation Services (DMHMRS), as the state mental health and mental retardation authority, to establish a Pre-Admission Screening and Resident Review (PASRR) for all persons requesting admission to or currently residing in a nursing facility. Through the PASRR evaluation, the Department determines whether: (1) the person requires nursing facility level of care; and whether NF level of care is the least restrictive environment in which care may be provided (2) if so, whether the person requires specialized services (active treatment).

Specifically, the **[PASRR program]** must assure the following:

- As of January 1, 1989, no person may be admitted to a Medicaid certified nursing facility without first being screened for mental illness or mental retardation/related condition. This provision applies regardless of the source of nursing facility payment.
- As a result of this pre-admission screening component (referred to as the Level I), persons who appear to have a mental illness or mental retardation/related condition will undergo a comprehensive assessment (referred to as the Level II) to determine the need for nursing facility care and specialized services (active treatment).
- As of April 1, 1990, all persons presently residing in nursing facilities, who entered the facility prior to January 1, 1989, will have been screened for mental illness or mental retardation/related condition (referred to as the initial resident review).

- **On October 19, 1996, the President signed P.L. 104-315 which amends Title XIX of the Social Security Act to repeal the requirement for annual resident review. The amendment requires nursing facilities to notify the STATE MENTAL HEALTH or MENTAL RETARDATION authority, as applicable, promptly after a significant change in the physical or mental condition of a resident who has a serious mental illness or mental retardation/related condition. The change in condition must affect either the resident's need for continued nursing facility placement or for specialized services. A review and determination under Section 1919(e)(7) of the Act must be done promptly after a nursing facility notifies the STATE MENTAL HEALTH/MENTAL RETARDATION authorities that there has been a significant change in the resident's physical or mental condition.**

1.1 RESPONSIBLE AGENCIES

1. Center for Medicare and Medicaid Services (CMS)

The Center for Medicare and Medicaid Services (CMS) is the federal agency which administers the Medicaid program.

2. Department for Medicaid Services

The Department for Medicaid Services (DMS) is the single designated state agency for the administration of the Title XIX program under the Social Security Act and is; therefore, responsible for administering the medical assistance program, including the issuance of policies, rules, and regulations on program matters, and making payments for vendor services provided to eligible recipients under the State Plan. As a condition of approval of the State Medicaid Plan, Kentucky is required to operate a Pre-Admission Screening and Resident Review (PASRR) program that meets the CMS regulatory requirements. The DMS is responsible for the following:

- a. assuring that the state mental health and mental retardation authorities, who are charged with making the required determinations, fulfill their statutory responsibilities;
- b. assuring that the state's PASRR program operates as it should, in accordance with the statute and OBRA regulations;
- c. assuring that the accounting, auditing, and enforcement of PASRR funding takes place; which includes withholding payment in cases

of non-compliance, and specifying an evaluation instrument that identifies applicants with mental health and mental retardation/related conditions. DMS cannot countermand determinations made by DMHMRS either in the claims process, utilization review, or state survey;

- d. assuring the two (2) determinations as to the need for nursing facility services and for specialized services are made based on a consistent analysis of the data;
- e. Assuring that [nursing facilities do not admit or retain] individual(s) with mental illness or mental retardation/related condition unless he or she has been screened and found to be appropriate for placement;
- f. Assuring that the resident assessments conducted by the nursing facility are coordinated with the state's PASRR evaluations, as required by Section 1919(b)(3)(E) of the Act; and
- g. Assuring the individuals who must be discharged under Section 1919(e)(7)(C) of the Act are discharged.

3. Department for Mental Health/Mental Retardation Services (DMHMRS)

The Department for Mental Health and Mental Retardation Services, as the designated state mental health and mental retardation authority, is responsible for assuring that the PASRR Level II evaluations are conducted, *and determinations are made*, in accordance with Federal regulations and DMS instructions. The state mental health and mental retardation authorities retain ultimate control and responsibility for the performance of their statutory obligations.

4. Community Mental Health/Mental Retardation Centers (CMHMRC)

The DMHMRS subcontracts with the 14 Community Mental Health/Mental Retardation Boards, which operate local community mental health/mental retardation centers throughout the state, to conduct the PASRR Level II evaluations for persons who have a mental illness or mental retardation/related condition.

5. Peer Review

The designated Peer Review Organization (PRO), through a contract with the DMS, provides the level of care determination for all Medicaid residents applying to or residing in Medicaid-certified nursing facilities. **As verification that a Pre-Admission Screening (PAS) Level I, and if appropriate, Level II evaluation has been done, State Medicaid regulations require that a copy of the Verbal Determination Form be faxed to the appropriate PRO office.** For persons with mental retardation/related conditions, this cannot be done until the Review Committee has made their determination.

6. Long Term Care Facilities (NF)

PASRR applies to facilities for which the state survey agency has granted an NF license and the department has granted certification for Medicaid participation. Swing beds are exempt from the PASRR process.

7. Office of Inspector General (OIG) previously L & R

OIG licenses all health care facilities, including nursing facilities, and annually monitors their compliance with regulatory standards. As part of an Interagency Agreement with DMS, OIG randomly reviews resident charts to assure that the Level I (MAP 409) and Level II evaluation (if appropriate) are completed.

1.2 PENALTY FOR NON-COMPLIANCE

1. State

The State must implement a PASRR program that meets the statutory requirements of 483.100 – 483.138. Failure by the State to operate a PASRR program in accordance with these requirements could lead to compliance actions against the State under Section 1904 of the Act “...particularly, the failure to implement the clear statutory mandates, such as subjecting all categories of individuals with mental illness or mental retardation (Medicaid, Medicare, and private pay) to PASRR and requiring nursing facility to not admit unscreened individuals, would be viewed as a failure to meet Medicaid state plan requirements. Compliance proceedings could result in loss of Federal Financial

Participation (FFP) in the state's Medicaid nursing home program until compliance is achieved."

2. Nursing Facility

It is the responsibility of the nursing facility to assure that the PASRR Level I screens are conducted on all applicants to the nursing facility, regardless of payor source, and that referrals for Level II evaluations are made when indicated. According to Section 1919(e)(7)(D) of the OBRA Act, failure to comply with the PASRR requirements may jeopardize Medicaid eligibility retroactive to the admission date for the applicant who was not appropriately screened, as well as the facility's participation in the Medicaid program.

3. Individual

Individuals who are found to have a mental illness or mental retardation/related condition through the Level I screen must participate in the Level II evaluation in order to be admitted to, or remain in, a Medicaid-certified nursing facility regardless of payment source.

DEFINITIONS

1.3 DIAGNOSIS

1. Mental Illness

An individual is considered to have a serious mental illness if he/she meets the following: a mental illness diagnosis, level of impairment, and duration of mental illness/recent treatment:

a) Diagnosis

The individual has a major mental disorder [as defined in the Diagnostic and Statistical Manual of Mental Disorders, *Third Edition, Revised (DSM-III-R)*] which includes: a schizophrenic; mood, paranoid, panic, or other severe anxiety disorder; somatoform disorder; other psychotic disorders; or other mental disorder that may lead to a chronic disability. This does not include a primary diagnosis of dementia, including Alzheimer's disease or a related disorder; or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above.

b) Level of Impairment

The disorder results in functional limitations in major life activities such as: interpersonal functioning; concentration; persistence and pace; and adaptation to change. These functional limitations must be evident within the last three (3) to six (6) months and must be appropriate for the person's developmental stage.

c) Recent Treatment/Duration of Illness

The individual has experienced at least one of the following:

- 1) Psychiatric treatment more intensive than outpatient care more than once in the past two (2) years (e.g., partial hospitalization, therapeutic rehabilitation, or inpatient hospitalization); or
- 2) Within the last two (2) years, due to the mental disorder, experienced a significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

2. Mental Retardation and Related Conditions

An individual is considered to have mental retardation if he/she has a level of retardation (mild, moderate, severe, or profound) as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983).

Mental retardation refers to significantly sub-average general intellectual functioning (I.Q. of approximately 70 or below) resulting in, or associated with, concurrent impairments in adaptive behavior and manifested during the development period before the age of 18.

The provisions of this section also apply to persons with "related conditions" as defined by 42 CFR 435.1009. "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

- a. It is attributable to:
 - 1) Cerebral palsy or epilepsy; or
 - 2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.
- b. It is manifested before the person reaches age 22.
- c. It is likely to continue indefinitely.
- d. It results in substantial functional limitations in three (3) or more of the following areas of major life activities:
 - 1) Self care;
 - 2) Understanding and the use of language;
 - 3) Learning;
 - 4) Mobility;
 - 5) Self-direction; or
 - 6) Capacity for independent living.

Examples of diagnoses that may indicate the condition if all of the above criteria are met include: autism, blindness/severe visual impairment, cerebral palsy, cystic fibrosis, deafness/severe hearing impairment, head injury, epilepsy/seizure disorder, multiple sclerosis, spina bifida, muscular dystrophy, orthopedic impairment, speech impairment, or spinal cord injury.

3. Dual Diagnosis

For purposes of PASRR, a person is considered dually diagnosed if he/she meets the criteria for serious mental illness and has a diagnosis of mental retardation or a related condition.

1.4 SPECIALIZED SERVICES (ACTIVE TREATMENT)

1. Mental Illness

Specialized services (active treatment) is defined as the implementation of an individualized plan of care developed and supervised by a physician and provided by an interdisciplinary team of qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of serious mental illness, which necessitates continuous supervision by trained mental health personnel. Specialized services (active treatment) require the level of intensity provided in a psychiatric in-patient service.

2. Mental Retardation

Specialized services for mental retardation/related condition is a continuous program for each resident which include aggressive, consistent implementation of a program specified by DMHMRS and provided by QMRP's that is directed towards the acquisition of behaviors necessary to function with as much self-determination and independence as possible and the prevention or deceleration of regression of current optimal functional status. These services may be provided in the nursing facility or in a less restrictive environment such as an ICF/MR or a community placement provided through Supports for Community Living Waiver funding, HCBW funding, group home, or other community placement with appropriate community supports. In making this determination, DMHMRS must make a qualitative judgment on the extent to which the person's status reflects, singly and collectively, the characteristics commonly associated with the need for specialized services, including:

A. Inability to:

- Take care of most personal care needs;
- Understand simple commands;
- Communicate basic needs and wants;
- Be employed at a productive wage level without systematic long-term supervision or support;
- Learn new skills without aggressive and consistent training;
- Apply skills learned in a training situation to other environments or settings without aggressive and consistent training;

Demonstrate behavior appropriate to the time, situation, or place without direct supervision; and
Make decisions requiring informed consent without extreme difficulty.

- B. Demonstration of severe maladaptive behavior(s) that place the person or others in jeopardy to health and safety; and
- C. Presence of other skill deficits or specialized training needs that necessitate the availability of trained MR/DD personnel, 24-hours a day, to teach the person functional skills.

NOTE: More information on the responsibility for implementing specialized services (active treatment) is found in PART IV, PASRR Administration and Support Activities.

1.5 SERVICES OF A LESSER INTENSITY

Nursing facilities are required by OBRA 1990 to provide mental health or mental retardation/related condition services, which are of a lesser intensity than specialized services to all residents who need such services. The PASRR evaluator is expected, as a part of the evaluation, to specifically identify these “generic” mental retardation/related condition or mental health services required to meet the individual’s needs. ***Evaluator should communicate and explain all recommended services of a lesser intensity for mental retardation/related condition or mental health service recommendations to nursing facility staff such as the director of nursing or the social service director. As often as possible, evaluators should follow up with the nursing facility to assure that recommendations are included in the resident’s plan of care.***

PASRR

Part II: Level I Screening

Part II: Level I Screening

2.1 DESCRIPTION

The Level I screening process is designed to identify individuals with mental illness or mental retardation/related condition. A Medicaid-certified nursing facility is responsible for assuring that the Level I is conducted prior to admission on all new applicants, regardless of payment source, and for all initial resident reviews. **The nursing facility is also responsible for initiating a Level I for current residents who experience a significant change in physical or mental condition that requires a subsequent review.**

2.2 MAP 409

The form used for Level I screening is the MAP 409 (See Part V, Forms). The MAP 409 includes the following screening criteria for mental illness/mental retardation:

1. a diagnosis of mental illness, mental retardation or related condition (except primary diagnosis of dementia, such as Alzheimer's disease or a related disorder for persons with mental illness);
2. functional impairment/limitations in major life activities due to mental illness (within the last three (3) to six (6) months); or
3. recent treatment for mental illness (within the last two (2) years) or history of mental retardation/related condition.

Types of Admissions

- A) Pre-admission: An individual is a new admission if he/she is admitted to any nursing facility for the first time or does not qualify as a re-admission. With the exception of certain hospital discharges described herein, all new admissions are subject to Level I screening.
- B) Re-admission: An individual is a re-admission if he/she was re-admitted to a nursing facility from a hospital to which he/she was transferred for the purpose of receiving care. Re-admissions are not subject to Level I screening but may be subject to a subsequent review if the person has experienced a significant change in condition as defined in 3.44 of this manual.

- C) **Inter-facility transfer:** An individual is an inter-facility transfer when he/she is transferred from one NF to another with, or without, an intervening hospital stay. Inter-facility transfers are not subject to Level I screening, but the transferring NF is responsible for ensuring that copies of the resident's most current PASRR documents accompany the transferring resident.

2.3 SCREEN FOR EXCEPTION AND DELAYED EVALUATIONS

If the person appears to have a mental illness or mental retardation/related condition based on the Level I screening criteria, then the person completing the MAP 409 reviews documentation to determine if the person meets any of the following:

1. Dementia Diagnosis

An individual is considered to have dementia if he/she has a primary diagnosis of dementia; including Alzheimer's Disease, or a related disorder, or a non-primary diagnosis of dementia, unless the primary diagnosis is a major mental disorder as defined on Page I-4 of this manual. For these persons, the PASRR process ends. (A dementia diagnosis cannot exempt a person with mental retardation from the Level II evaluation process.)

2. Exempted Hospital Discharge (Admissions to Nursing Facility for Less Than 30 Days)

An exempted hospital discharge means an individual with a diagnosis of mental illness or mental retardation/related condition who meets NF level of care:

- a. who is admitted to any nursing facility directly from a hospital after receiving acute in-patient care at the hospital;
- b. who requires nursing facility care for the condition for which he or she received care in the hospital; and
- c. **whose attending physician has certified before admission to the facility that the individual is likely to require less than thirty (30) days nursing facility care.**

If an individual who enters the nursing facility, as an exempted hospital discharge is later found to require more than thirty (30) days of nursing facility care, the CMHMRC must conduct a PASRR evaluation within forty (40) calendar days of admission.

The nursing facility must refer the individual for a PASRR Level II evaluation as soon as it is known that nursing facility level of care is required for more than thirty (30) days from admission.

3. Advance Group Determination for Nursing Facility Level of Care (Provisional Admission for Less than 14 Days)

An advance group determination, or provisional admission, is one in which the Level I reviewer, after nursing facility certification, takes into account certain diagnoses or the need for a particular service which clearly indicates that admission into, or residence in, a nursing facility is normally needed. Persons who enter the nursing facility under the provisional admissions category do not require an individualized evaluation to determine that specialized services are needed prior to admission. However, a request for a Level II PASRR should be made with each provisional admission if he/she is not going to be discharged within the fourteen (14) days. The nursing facility will not be eligible for reimbursement after the fourteenth day of the admission date until a PASRR determination is made authorizing nursing facility level of care. The PASRR evaluation must be completed within nine (9) working days of the Level I referral.

Provisional admission includes:

- 1) A diagnosis of delirium as defined in the DSM[IIIR], allows for a fourteen (14) day admission pending further assessment, when an accurate diagnosis cannot be made until the delirium clears.
- 2) Respite is allowed to in-home caregivers to whom the person with mental illness or mental retardation/related condition is expected to return following a stay of fourteen (14) days or less.

Note: Convalescent Care, Terminal Illness, and Severity of Illness Categories no longer exist.

2.4 WRITTEN NOTICE OF LEVEL I FINDING

In the case of a first time identification of mental illness or mental retardation/related condition, the Level I reviewer must provide written notice to the individual or resident and his or her legal representative that the individual is suspected of having mental illness, mental retardation, or a related condition and is being referred for a Level II evaluation.

2.5 REQUEST FOR PASRR LEVEL II EVALUATIONS

A request for a PASRR Level II evaluation follows the completion of a positive MAP 409. In most instances, only a nursing facility with an available bed (vacancy) will request a PASRR evaluation for a new admission or advance group determination for provisional admission. An acute care hospital may not initiate a Level I referral to the CMHMRC. However, to facilitate the placement of persons with mental illness or mental retardation/related condition who would be difficult to place within the confines of the routine PASRR placement procedures, two (2) exceptions have been made, as follows:

1. A nursing facility without a vacancy can request a PASRR Level II evaluation upon the completion of a positive MAP 409 as long as there is a reasonable expectation that the person will be admitted when a vacancy occurs.
2. DMHMRS and DMS have designated the following agency staff as appropriate to initiate a request for a PASRR evaluation directly to the CMHMRC:
 - a. state guardianship officers;
 - b. CMHMRC staff;
 - c. Department for Community Based Services (formerly DSS) adult services staff, with the approval of center PASRR coordinator;
 - d. state operated or contracted psychiatric hospital discharge planners; and
 - e. private psychiatric hospital discharge planners, with approval of center PASRR coordinator.

It is hoped that having a completed PASRR Level II evaluation in hand at the time of the agency's contact with the facility will assure the facility of the appropriateness of the referral and will reduce the facility's reluctance

in admitting these individuals. The referral source (i.e., state guardianship, psychiatric hospitals, etc.) is expected to be reasonably sure that the individual, if a Medicaid recipient, will meet the nursing facility level of care criteria, and is also expected to provide (as much as possible) the information needed.

A request for a subsequent Level II evaluation will occur when the nursing facility and/or PRO determines that a resident has experienced a significant change in their physical or mental condition, which will impact the individual's need for continued placement or their specialized services needs.

PASRR

Part III: Level II Evaluation

Part III: Level II Evaluation

3.1 DESCRIPTION

As a result of the Level I screening, persons who appear to have mental illness and/or mental retardation, or a related condition, must undergo a Level II comprehensive evaluation. [FFP is available only for services furnished after the screening or review has been performed.] The Level II evaluation determines whether the person:

1. Requires level of nursing facility care provided by NF and these needs cannot be met in a less restrictive environment; and if so,
2. Requires specialized services (active treatment) for mental illness/mental retardation or a related condition.

3.2 EVALUATION INFORMATION

1. Information To Be Collected

Necessary information must be gathered on all portions of the PASRR evaluation to determine the most appropriate treatment setting. If a portion of the PASRR evaluation does not apply to an individual applicant or resident, the reason must be noted in that section or write N/A (Not Applicable).

PASRR evaluations must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated.

When parts of a PASRR evaluation are performed by more than one evaluator, there must be interdisciplinary coordination among the evaluators.

A. Specific data for mental illness includes:

- a comprehensive history and physical examination;
- a comprehensive drug history;
- a psychosocial evaluation;
- a mental status evaluation and documentation of psychiatric treatment; and
- a functional assessment of activities of daily living ability.

B. Specific data for mental retardation includes:

- a comprehensive history and physical examination;
- current medications and the response of the applicant or resident to particular psychotropic medications;
- self-monitoring of health status, medical treatments, and nutritional status;
- development of skill areas such as self-help, sensorimotor, speech and language, social, academic/educational, independent living, and vocational;
- the presence of identifiable maladaptive or inappropriate behaviors; and
- a psychological evaluation, including a written report, signed by, or counter-signed by, a licensed psychologist. If a psychological evaluation from another source (i.e., ICF/MR, school program) is already available, and the information remains current, it is not necessary to do another, but a copy must be attached. If an individual is unable to be tested, an abbreviated written report, with appropriate signature, which states this, and also gives a diagnosis of “MR”, Severity Unspecified (319.0), is required.

NOTE: There will be instances where history alone may verify the presence (or absence) of mental retardation before the age of 18 (i.e., it would not be necessary to perform a new psychological evaluation for a person of advanced years to verify that the person meets the age criterion of the definition for mental retardation/related condition).

C. Specific data for dual diagnosis of mental illness and MR/related condition includes:

- The complete Level II evaluation for mental retardation/related condition; and
- The mental status/psychiatric assessment portion of the comprehensive evaluation for mental illness.

D. Individualized evaluation information that is necessary to determine if it is appropriate for the individual with mental illness or mental retardation/related condition to be placed in a nursing facility or in another appropriate setting should be gathered throughout all applicable portions of the PASRR evaluation. The two (2) determinations relating to the need for nursing facility level of care and specialized services are inter-related and must be based upon a comprehensive analysis of all data concerning the individual.

- E. Evaluators may use relevant evaluative data obtained prior to initiation of pre-admission screening or a subsequent review if the data are considered valid and accurate and reflect the current functional status of the individual. More information may be needed to supplement and verify the timeliness and accuracy of the existing data.
- F. Findings of each evaluation must correspond to the person's current functional status as documented in medical and social history records.

NOTE: Nursing facility resident's rights include the right to refuse treatment, including specialized services. However, a resident's refusal of treatment must be persistent and consistently documented in the resident's record.

- G. For PASRR determinations, findings must be issued in the form of a written evaluative report which:
 - identifies the name and professional title of the person(s) who performed the evaluation(s) and the date on which each portion of the evaluation was administered. For MR evaluations, the title, "QMRP", should be *added* to the evaluator's signature;
 - provides a summary of the medical and social history, including the positive traits or developmental strengths and needs;
 - identifies the recommendations for treatment which include:
 - ✧ the specific nursing services required to meet the evaluated person's needs if nursing facility services are recommended;
 - ✧ any specific mental retardation/related condition or mental health services which are of a lesser intensity than specialized services, if specialized services (active treatment) are not recommended;
 - ✧ if specialized services are recommended*, identifies the specific mental retardation/related condition or mental health services required to meet the evaluated person's needs; and

* For more information, refer to Part IV, 4.5, Responsibility for Providing Specialized Services (Active Treatment).

- ✱ if specialized services are recommended*, the recommendation is reviewed and signed by a board-certified psychiatrist for a person with mental illness, or a licensed psychologist for a person with mental retardation/related condition.

- includes the basis for the report's conclusions.

2. Information From Other Sources

Current and relevant assessment information obtained from other sources may be used. The decision concerning the timeliness and appropriateness of the information is the responsibility of the person completing the PASRR. Copies of the information must be attached to the PASRR evaluation.

In completing the PASRR evaluation for current residents, Center staff may be reviewing and using information that is already part of the resident's record. If existing information is incorporated into the Center's PASRR evaluation, the information must be summarized on the PASRR evaluation form, including the source (i.e., date, name, title of the person, etc.). The referenced information does not have to be attached to the PASRR evaluation form returned to the facility.

3. Participation by Individual and Family

The applicant must be seen and an interview attempted by a PASRR evaluator. In most cases, the evaluation should occur in the applicant's home or current residence/location. If the person is unable to significantly contribute to the interview, the reason must be documented on the evaluation form.

PASRR evaluations must involve:

- The individual being evaluated;
- The individual's legal representative, if one has been designated under state law; and
- The individual's family with consent from the individual.

* For more information, refer to Part IV, 4.5, Responsibility for Providing Specialized Services (Active Treatment).

4. Permission for Treatment

The DMS has concluded that specific release of information and treatment forms are unnecessary based on state regulations 907 KAR 1:460, Coverage and Payment for PASRR. This states that the regulation is applicable to all individuals desiring admission to, or continued stay in, a Medicaid-certified facility and that any individual seeking admission or continued stay shall be deemed to have given consent for the state to conduct PASRR. Any re-disclosure of information is subject to release of information form.

5. Client Signature and Interpretation of Findings

Center for Medicare and Medicaid Services (CMS) regulations mandate that the findings of the PASRR evaluation be interpreted to the applicant, and where applicable, to a legal representative designated under state law. This is documented by signature on the evaluation form. For persons with mental retardation/related condition, the findings cannot be made known until the final determination is made by the Department of Mental Health and Mental Retardation Services PASRR Review Committee.

3.3 DISCONTINUATION/LEVEL II NOT INDICATED

The PASRR process is to be discontinued if at any time it is found that the applicant does not have a mental illness; mental retardation or a related condition; or has a primary diagnosis of dementia (including Alzheimer's Disease or a related disorder). The finding must be documented on the evaluation form and the case record filed to substantiate the billings for time involved in the evaluations. If it is determined during a subsequent review that a person has a dementia diagnosis, the record must include appropriate clinical data to substantiate this diagnosis. [A dementia diagnosis cannot exempt a person with mental retardation from the Level II evaluation process.]

Dementia Exception Established by the Evaluator

If dementia is suspected on a Level II referral, then the CMHC evaluator may make an exception based on a primary diagnosis of dementia by: completing a mini mental status exam (must be co-signed by CMHC psychiatrist); verifying documentation in the record of diagnostic testing (such as CT Scan); a mental status examination conducted by a physician; or a history/physical by a physician which documents a diagnosis of dementia. **PASRR evaluators must clearly document data to substantiate the dementia diagnosis. If the dementia diagnosis is substantiated, the PASRR is to be discontinued.**

3.4 TYPES OF EVALUATIONS

1. Consultation Contacts

Consultation contacts are designed to eliminate unnecessary PASRR referrals. A consultation contact is a ***brief*** face-to-face conversation or a telephone call between the nursing facility and PASRR Center staff (qualified mental health/mental retardation professionals as defined in Part IV, Section 4.3, Personnel PASRR staff qualification) about the Level I or referral that does not lead to a PASRR evaluation. Consultation contacts should be limited to no more than 30 minutes (two units) of staff time per contact, with the average time being one unit (15 minutes). During a consultation, the facility may identify specific client(s) or issues which are not client specific. These contacts must be documented, including giving the date, name of person/facility/client, and the purpose of the contact. The record of the contact should be maintained at the Center using existing Center procedures.

Centers may request reimbursement for consultation contacts by the nursing facilities, regarding the Level I process, that do not lead to a PASRR evaluation. A PASRR consultation unit of service is billed in ¼-hour units.

For billing purposes, the date of the contact, what type of contact (i.e., consultation), and the amount due must be included on the PASRR billing form. Consultation contacts do not require client ID numbers.

NOTE: Centers may request reimbursement for consultation contacts by mental health associates, as defined in Part IV, Section 4.3, Personnel, without a counter signature.

2. Pre-Admission/New Admission

A person is considered a new/pre-admission for PASRR when the person has triggered a Level I referral and is:

- requesting admission to a nursing facility for the first time or does not qualify for a re-admission;
- currently residing in the community;
- residing in a lower level of facility care (family care, personal care home), or ICF/MR; or
- transferring from a lower level of care within the same facility.

NOTE: A Pre-Admission PASRR is not required for a person seeking re-admission to a nursing facility if a Level II evaluation was conducted previously and the information remains current. The PASRR coordinator may request documentation and/or additional information to determine if information remains current.

NOTE: The convalescent care exception is no longer valid. This exception allowed persons to be discharged from an acute care hospital to a nursing facility and receive a PASRR evaluation within 105 days of admission. Now, all hospital discharges that do not qualify for the exempted hospital discharge, or for re-admission, must receive an evaluation prior to nursing facility admission.

3. Initial Resident Reviews

A person is considered for an Initial Resident Review if the person is presently in the facility, does not qualify as a new admission, and:

- was admitted to a Kentucky nursing facility under the exempted hospital discharge exception and remained in the facility beyond thirty (30) days;
- was admitted to the nursing facility under an advanced group determination as a provisional admission (delirium and respite) and remained beyond fourteen (14 days); or
- was admitted to the nursing facility and the prior Level I did not trigger a Level II referral and now requires a Level II evaluation because of updated information.

NOTE: For the purposes of PASRR billing, an initial resident review is considered a pre-admission.

4. Subsequent Review

Nursing facilities must notify the state mental health or mental retardation authority (CMHCs), as applicable, promptly after a significant change in physical or mental conditions of a resident who is mentally ill, or has mental retardation, or a related condition. Significant change is defined as a change in a resident's health or mental status which has a bearing on his or her active treatment needs (specialized service needs). Upon notification, the CMHMRC must promptly conduct a review and determination after the nursing facility has notified them of the significant change.

NOTE: Promptly is defined as no more than twenty-one (21) days for nursing facilities to notify the CMHMRC after a significant change has occurred. "Promptly" for the evaluator is the same as that for a pre-admission screen. (3.5)

3.5 TIME FRAMES FOR COMPLETING EVALUATIONS

1. Pre-Admission/New Admissions

- A. Pre-admission/new admission Level II evaluations must be completed and forwarded to the appropriate parties within nine (9) working days of referral of the individual with mental illness or mental retardation/related condition. The nursing facility will fax the Verbal Determination Form to the PRO so as not to delay the admission process.

NOTE: This process is not completed for persons with mental retardation/related condition until authorization/approval has been granted by the DMHMRS Review Committee.

- B. Requests for extensions beyond nine (9) days from the receipt of the referral require prior approval from DMHMRS/Director, Division of Mental Health/Mental Retardation. A letter justifying the delay must accompany the computer summary form. In addition, the CMHMRC must notify the nursing facility staff and referral source immediately, provide the reason for the delay, and give the anticipated date of PASRR completion.

2. Initial Resident Reviews

Initial resident reviews are to be completed within the time frames identified in each category defined below:

- A. Exempted Hospital Discharge

If an individual is admitted to the nursing facility under this category, and requires more than thirty (30) days of nursing facility services, an initial resident review must be completed within nine (9) working days of the Level I Referral or within forty (40) calendar days of admission.

B. Provisional Admissions

Individuals admitted to the nursing facility as a provisional placement as defined in Part II, 2.3, #3 of this manual (for delirium or respite), must receive an initial resident review no later than fourteen (14) days after admission if it is anticipated that the need for nursing facility services will exceed fourteen (14) days; thereafter, the nursing facility will not be eligible for reimbursement.

C. New to PASRR

If an individual's previous Level I did not trigger a Level II referral and now requires a Level II evaluation due to updated information, the evaluation must be completed within nine (9) working days of the referral.

3. Subsequent Reviews

Individuals referred for a subsequent review must be evaluated and have a determination made within nine (9) working days of the referral.

4. Evaluations That Fail to Meet Time Frames

All computer summary forms sent to the Division of Mental Health or Mental Retardation that indicate evaluation determinations were not completed within the designated time frame must have attached a detailed explanation of the reason for non-compliance. If this documentation is not present, forms will be returned to the Center for re-submittal and the payment for units associated with the evaluation may be delayed.

Evaluation Submission Time Frames

Evaluations are delinquent if they fail to meet the following time frames:

1. Pre-admission ~~ Must be completed within nine (9) working days of referral.
2. Subsequent review ~~ Must be completed within nine (9) working days of referral.

3. Exempt Hospital Discharge ~~ Must be completed within nine (9) working days of Level II Referral (or forty (40) calendar days of admission).
4. New to PASRR ~~ Must be completed within nine (9) working days of referral.
5. Provisional ~~ (Respite and Delirium) Must be completed within fourteen (14) calendar days of admission or nine (9) working days of referral.

3.6 VERBAL DETERMINATION FORM

If the PASRR evaluator is able to provide a verbal determination within five (5) days or less, the verbal determination form must be completed and faxed to the nursing facility.

3.7 ASSESSMENT FORM

All evaluation reports must be completed on the Comprehensive Evaluation Form. (See Part V of this manual.) This form is used to gather the information in a report format. Staff notes, etc., should also be utilized, if additional components are necessary to give a comprehensive evaluative report.

3.8 PERSONNEL

(For additional staffing qualifications, see Part IV, Administrative and Support Activities, Personnel.)

DMHMRS contracts with the CMHMRC to conduct the Level II PASRR. PASRR must be conducted:

- either independently by one of the Qualified Mental Health Professionals so designated in the Kentucky Medical Assistance Manual, or selected Qualified Mental Retardation Professionals so designated in Part IV of this manual.
- by a Mental Health Associate who does not meet the above criteria, with a counter-signature by one of the above professionals. A Mental Health Associate may not evaluate persons with mental retardation or related condition.

NOTE: A determination for specialized services for mental illness does require a counter-signature of a board eligible psychiatrist. A determination

for specialized services for mental retardation or related condition does require a counter-signature of a licensed psychologist.

Training

All PASRR coordinators and all CMHMRC staff who bill for PASRR units must complete a PASRR Evaluator Certification Training offered and approved by the DMHMRS. (For more information, see Part IV of this manual.)

Conflict of Interest

PASRR regulations prohibit persons or entities that perform evaluations from having a direct or indirect affiliation or relationship with a nursing facility. Thus, CMHMRC staff that subcontract with nursing facilities to provide consultation or mental health/mental retardation services may not conduct PASRR evaluations in those facilities.

3.9 DISTRIBUTION OF THE COMPREHENSIVE EVALUATION REPORT

A copy of the complete evaluation report must be sent to the:

- individual and legal representative (if applicable);
- appropriate DMHMRS Division (the MH evaluation is sent to DMH only if specialized services are recommended);
- admitting or retaining nursing facility.

A copy of the cover sheet and review of findings for all reviews, must be sent to the:

- individual's attending physician;
- discharging hospital, if individual is seeking nursing facility admission from a hospital.

3.10 OUT-OF-STATE REFERRALS

New admissions from out-of-state are subject to Level I screening, and if appropriate, a Level II comprehensive evaluation and determination. The state in which the individual is a state resident (or would be at the time he/she becomes eligible for Medicaid) must pay for the PASRR.

3.11 OUT-OF-REGION REFERRALS

If the person requiring the PASRR evaluation is located in a region other than the region where the facility requesting the PASRR is located, the Center in the region where the person is located is responsible for completing the assessment. The Center receiving the initial referral from the nursing facility, will contact the Center where the person is located to request that the PASRR be done in that region and forwarded to the receiving region. Exceptions should be worked out between the Centers. Please indicate on the PASRR Computer Summary form submitted to the DMHMRS the region of the nursing facility where the individual was admitted.

3.12 MEDICAL/SPECIALTY EXAMINATIONS

As previously stated, it is the intent of the DMS that the PASRR reimbursement be inclusive of all PASRR costs. However, DMS will reimburse the DMHMRS (and subsequently the Centers) for the cost of additional medical/specialty examinations that are needed to complete the PASRR assessment and are beyond the expertise of the PASRR staff to perform. The need for additional examinations should be the exception rather than the rule. This option should be used with discretion.

Procedures for arranging for the additional examinations are:

- The Center psychiatrist must authorize the referral and include a statement in the record as to the purpose of the examination and its relationship to the PASRR evaluation.
- The Center must pay for the examination and then request reimbursement from the DMHMRS.

NOTE: Even if the examination is covered by an individual's existing Medicaid card, under no circumstances should the Medicaid card be used. This process must be adhered to as DMS wishes to show the full cost of

all PASRR activities related to Medicaid clients. The federal share of the cost for PASRR activities is greater than for other Medicaid activities.

3.13 THIRTY-MONTH STAY

A long-term resident is defined as an individual who has resided in a nursing facility for at least thirty (30) months before the date of the first determination that he/she does not require nursing facility services. If a long-term resident requires a 30-month stay, he/she may continue to reside in a nursing facility, even if he/she does not meet nursing facility criteria.

For purposes of determining the individual's length of stay in a nursing facility, the evaluator should calculate back from the date on which the individual was initially found, on the basis of a subsequent review, not to require nursing facility placement. Temporary absences from a nursing facility for hospitalization, therapeutic leave, or home visits are to be included in determining a resident's continuous length of stay. Consecutive residences in more than one nursing facility also should be counted as part of a single length of stay.

NOTE: Any NF resident who meets the 30-month option must have a placement option form completed.

PASRR

Part IV: PASRR Administrative and Support Activities

Part IV: Administrative and Support Activities

4.1 APPEALS PROCEDURES

Federal law requires that there be an appeals procedure for those nursing facility applicants or residents who receive an adverse determination based on the PASRR evaluation. The adverse determination could be that the applicant/resident does not require a nursing facility level of care and/or that the applicant/resident does or does not need specialized services (active treatment) for a serious mental illness or mental retardation/related condition.

The procedure for persons with mental illness and mental retardation/related condition differ. When specialized services are recommended for individuals with mental retardation/related condition, the determination is not final, and therefore, not appealable, until a ruling is made by the DMHMRS PASRR Committee. (See Section 4.6 for specific instructions.)

The Department for Medicaid Services must be responsible for maintaining a fair hearing process to accommodate the appeals procedure. The state's hearing system provides one level of appeals with the following requirements:

- **The Center must notify the applicant/resident, or his or her legal representative, within two (2) working days of the determination.**
- **An applicant, resident, or representative may request a hearing by filing a written request with the Department for Medicaid Services within thirty (30) days of the date of the letter. If the request for a hearing is postmarked or received within ten (10) days of the date of this letter, a resident may continue to stay in a nursing facility (if previously admitted) until the final cabinet level hearing. An individual may be represented at the hearing by oneself, a friend or relative, spokesperson or other authorized representative, including legal counsel as specified in 907 KAR 1:563.**
- **The applicant, resident, or representative will be notified of the date, time, and place of the scheduled hearing, which will be conducted within thirty (30) days of the date of the request for a hearing. This notification, will also include further instructions as to representation and other rights.**

- **Requests for the appeal hearing should be submitted directly to:**

**The Division of Administration and Financial Management
Administrative Services Branch
Mail Stop 6W-C
275 East Main Street
Frankfort, KY 40621**

The Appendices Section of this manual, includes cover letters to accompany copies of each type of evaluation **and appeals procedures**. Information from these documents should be incorporated into the Center's procedures.

4.2 FINANCIAL

Request for reimbursement shall be made to the Operations Branch in the Division of Administration and Financial Management (DMHMRS), pursuant to instructions issued in the Department's Program Policies and Billing Instructions Manual (PPBIM). For more information, refer to Billing Instructions, found in the Appendices Section of this manual. PASRR units include not only face-to-face contact, but time spent in activities such as travel, record keeping, and collateral contacts. Only qualified mental health/mental retardation staff (as determined by DMS) may bill for PASRR units. Support staff and other non-qualified staff cannot bill for PASRR units.

1. Cost Report

PASRR activities shall be considered DMHMRS fundable services and all associated costs will be accumulated in a separate cost center when preparing the annual cost report.

2. Additional Examinations

The DMS will reimburse the DMHMRS for the cost of additional medical/specialty examinations. For more information, refer to Part III, 3.12, Medical/Specialty Examinations.

3. Evaluations Exceeding \$500

The DMS has asked the DMHMRS to review all PASRR MI/MR evaluations that exceed a total cost of Five Hundred Dollars (\$500.00) and dual diagnosis evaluations that exceed a cost of Seven Hundred

Fifty Dollars (\$750.00). PASRR evaluator staff will be asked to submit documentation to the DMHMRS justifying the number of units and the variables, such as travel time, professional consultation, and difficulty in securing records that contribute to the increase in the PASRR units. The Explanation of Billing form located in Part V will be used for documentation.

4.3 PERSONNEL

1. PASRR Staff Qualifications

PASRR staff must meet the criteria of one of the following professionals recognized by the DMS or the DMHMRS **[(refer to respective standards manuals and regulations)]**:

A. Qualified Mental Health Professional

- Psychiatrist;
- Master Social Worker;
- Psychologist;
- Psychiatric Nurse (R.N.); or
- Professional Equivalent, which is:
 - ➡ Bachelor's degree, identical field, three (3) years full-time equivalent supervised;
 - ➡ master's degree, identical field, six (6) months full-time equivalent supervised experience; or
 - ➡ Doctorate degree, identical field.

Identical field is defined as Psychology, Sociology, Social Work, or Human Services as determined by PE Review Committee.

- B. Mental Health Associate ~~ An individual with a minimum of a bachelor's degree in a mental health related field.

PASRR conducted by a mental health associate, as designated in the Kentucky Medical Assistance Manual, requires a counter-signature by one of the recognized mental health professionals listed above.

- C. Qualified Mental Retardation Professional ~~ means a person who has one (1) year of experience in treating or working with persons with mental retardation, and is one of the following:

1. A psychologist with a master's degree from an accredited program.
2. A licensed doctor of medicine or osteopathy.
3. An educator with a degree in education from an accredited program.
4. A social worker with a bachelor's degree in ~~
 - a. Social work from an accredited program; or
 - b. A field other than social work and at least three (3) years of social work experience under the supervision of a qualified social worker.
5. A registered nurse.

2. PASRR Certification

All PASRR coordinators and all CMHMRC staff who bill for PASRR units must complete a PASRR Evaluator Certification training offered and approved by the Department for Mental Health and Mental Retardation Services. PASRR evaluators must be certified within three (3) months of his/her assignment to the PASRR program. Because there may be situations, such as staff illnesses or vacations, in which certified staff may not be available, the CMHMRC may designate back-up staff to conduct evaluations on a limited basis. Although these staff do not require certification, they must be familiar with the PASRR process and have access to the PASRR manual. The CMHMRC is expected to provide a listing of back-up staff to the Division of Mental Health at the

beginning of each fiscal year end and to advise the Division of any changes throughout the year.

3. PASRR Coordinators

Each region is expected to designate a PASRR Coordinator to be responsible to administer and coordinate the PASRR activities for the region. PASRR Coordinators' duties include, but are not limited to, the following:

1. Assure that all staff who bill for PASRR services are trained and certified in PASRR policies and procedures;
2. Distribute manual revisions, computer summary data, and related information on a timely manner, upon receipt of information from the DMHMRS and DMS;
3. Regularly review completed evaluations and records for compliance with policies and procedures, including timelines and content;
4. Be available for consultation to the CMHMRC staff;
5. Coordinate local training for PASRR staff, nursing facilities, and others as needed; and
6. Assure that required forms and information are submitted to the DMHMRS.

NOTE: PASRR Coordinators must meet the criteria of professional staff and must be certified.

4.4 RECORD KEEPING

A mental health/mental retardation center shall have a separate file for each person who receives a Level II PASRR evaluation. Each record should include at least the following:

1. Referral (MAP 409 and/or Center intake form);
2. Initial and Subsequent Comprehensive Evaluation (including necessary attachments);
3. Copies of reports, evaluations, tests, etc., related to PASRR;
4. Interpretation of Findings;
5. Computer Summary Form;
6. Staff notes, if necessary;

7. Correspondence related to PASRR (which includes the DMR letter);
8. Documentation to substantiate units billed, including billing tickets, if appropriate; and
9. Summary report.

NOTE: Records of consultation contacts should also be maintained in the center.

4.5 RESPONSIBILITY FOR PROVIDING SPECIALIZED SERVICES

The Department for Mental Health and Mental Retardation Services (DMHMRS) is meeting its responsibility to provide specialized services by contracting with the Comprehensive Care Centers for the provision of those services for mental retardation/related condition and for arranging for these services for mental illness.

4.5 DETERMINATIONS FOR PERSONS WITH MENTAL ILLNESS

Center-designated PASRR staff is expected to conduct the Level II evaluation and to arrange or provide specialized services, if recommended. Specialized services are narrowly defined as comparable to those services an individual would receive in an acute psychiatric in-patient facility. In addition, the individual must meet the definition of serious mental illness. The law specifically excludes from the Act individuals who have a primary diagnosis of dementia, including Alzheimer's or a related disorder.

Center-designated PASRR staff who identify an individual, through the PASRR process, as being in need of specialized services for mental illness, are responsible for developing and implementing a plan for specialized services to the degree possible, through the use of existing resources. Center PASRR staff are not responsible for arranging for the placement or discharge of a person who is in need of specialized services to another setting, other than to an in-patient psychiatric facility for the person who has a mental illness.

Mental Illness/Pre-admission

Center-designated PASRR staff is responsible for arranging for the provision of specialized services in the community for those individuals identified in need of such treatment through the PASRR evaluation and for whom nursing facility level of care is not recommended. The staff will work with the individual or the designee in arranging placement, either in a private or state psychiatric facility. If the individual declines specialized services, the Center PASRR staff will assess the need for involuntary commitment

and proceed, if appropriate, in arranging such. If involuntary commitment proceedings are not warranted, the Center PASRR staff will assess the appropriateness of serving the person through out-patient mental health services, and if appropriate, will refer the person to other social service agencies (such as Protection and Permanency). The Center PASRR staff is not responsible for arranging for alternative residential placement.

Mental Illness/Current Residents (More than 30 months)

Individuals who have resided in the nursing facility for more than thirty (30) months and have been determined to be in need of specialized services, but not in need of nursing facility care, may choose to remain in the nursing facility and receive specialized services. It will be the responsibility of the Center PASRR staff to arrange for the specialized services. If the person chooses to be discharged and receive specialized services, the Center will arrange for admission screening, either at a private or state psychiatric facility. Center PASRR staff are not responsible for arranging for the discharge of the individuals to another alternate setting. If the individual returns to the community, Center PASRR staff will assess the person for appropriateness of receiving outpatient mental health services.

Mental Illness/Current Residents (less than 30 months)

If the individual has been in the nursing facility less than thirty (30) months and no longer requires nursing facility level of care, PASRR staff will arrange for admission screening either at a private or state psychiatric facility. If the individual declines specialized services, and involuntary commitment proceedings are not indicated (person is not dangerous to self or others), then the person may not remain in the nursing facility under the auspices of the ADP. The Center PASRR staff will work with the nursing facility, the individual, the designee, and other agencies to devise a discharge plan that includes providing mental health services in the community. The Center is not responsible for arranging for the person's discharge from the nursing facility when the person will not voluntarily seek treatment in an inpatient setting or is not appropriate for involuntary placement.

4.7 DETERMINATIONS FOR PERSONS WITH MENTAL RETARDATION /RELATED CONDITION

The determination function is a consistent and comprehensive analysis of all the data available to determine both an individual's need for nursing facility level of care and need for specialized services. Without exception, any applicant for admission to a nursing facility who has mental retardation/related condition and who does not require the level of care

provided by the nursing facility, regardless of whether specialized services are also needed, are inappropriate for nursing facility placement and must not be admitted. DMHMRS strongly urges CMHMRC staff to assist these individuals in obtaining supportive services to enable them to continue residing in the community.

Mental Retardation/Related Condition-Pre-Admission

Placement of an individual with mental retardation/related condition in a nursing facility may be considered appropriate only when the individual's needs for treatment do not exceed the level of services which can be delivered in the nursing facility to which the individual is admitted either through nursing facility services alone, or where necessary, through nursing facility services supplemented by specialized services arranged by the local CMHMRC.

Mental Retardation/Related Condition—Current Resident

If DMHMRS determines the resident does not require a nursing facility level of services and does not require specialized services, regardless of their length of stay, CMHMRC must arrange for the safe and orderly discharge of the resident from the nursing facility and prepare and orient the resident for discharge.

If DMHMRS determines the resident does require nursing facility level of care and does require specialized services, the resident can continue to stay, regardless of their length of stay, in the nursing facility placement if determined appropriate.

If DMHMRS determines the resident does not require nursing facility level of care but does require specialized services, for residents of less than thirty (30) months from the date of determination, in consultation with the resident's family or legal representative and caregivers, CMHMRC must arrange for the safe and orderly discharge of the resident from the nursing facility and prepare and orient the resident for discharge and provide for, or arrange for, the provision of specialized services.

If DMHMRS determines the resident does not require nursing facility level of care but does require specialized services, for residents of more than thirty (30) months from the date of determination, CMHMRC must offer the resident the choice of remaining in the nursing facility or receiving services in an alternative appropriate setting; inform the resident of the institutional and non-institutional alternatives covered under the State Medicaid plan for the resident, and regardless of the resident's choice, provide for, or arrange for, the provision of specialized services.

4.8 DMR COMMITTEE REVIEW

All Level II evaluations (including change of condition) must be sent to the Division of Mental Retardation for review by the Department PASRR Committee. The individual/family/legal representative is not notified until notice of the determination is received. In order to meet the timeframes set by Federal regulations, the following procedures should be adhered to:

1. Upon completion, FAX the entire PASRR evaluation, including the psychological evaluation and medical information to:

**Karen Edens
Division of Mental Retardation
FAX: (502) 564-0438**

2. Staff from the Division will circulate the evaluation to all members of the Review Committee for a determination.
3. A letter noting the Committee's decision will be faxed back to the submitting region (one (1) –day turnaround if possible), with the original to follow by mail. As appropriate, the letter will be supported by assurances that the specialized services that are needed should be provided by the CMHMRC while the individual resides in the nursing facility.
4. The CMHMRC will then notify the nursing facility and resident/legal representative of the final determination by sending the appropriate cover letter explaining the findings and appeal process. To comply with completing determination notifications within an annual average of nine (9) days, the CMHMRC may convey the final determination verbally to the nursing facility and individual/legal representative with written confirmation to follow.

If the family/legal representative is present during the resident interview, they may already be aware that the evaluation will include a recommendation for specialized services and they should have been informed of placement options and available services. However, it must be explained to them that the decision is not final until the PASRR Review Committee makes its decision.

NOTE: If the individual/legal representative refuses specialized services, this must be documented in the evaluation.

4.9 APPEAL PROCESS

All appeal hearings (to be included in determination notice) will be conducted by administrative hearing officers in the Cabinet for Health Services. Only you or your authorized representative, acting on your behalf, may request a hearing if the determination is adverse in any respect.

In order to exercise this right, you or your authorized representative must file a written request clearly indicating a desire for a hearing within thirty (30) days from the date of this notification. The request for a hearing shall be filed directly to the Cabinet for Health Services:

**The Division of Administration and Financial Management
Administrative Services Branch
Mail Stop 6W-C
275 East Main Street
Frankfort, KY 40621**

If you request a hearing, you may represent yourself or be represented by an authorized representative, such as legal counsel, relative, friend, or other spokesperson. You may contact the Department for Community Based Services located in your county of residence regarding the availability of free representation by legal aid services.

Your request for a hearing shall be acknowledged by the Cabinet for Health Services, and you will receive information regarding the hearing process.

PASRR

Part V: FORMS

Part V: FORMS

I. DEFINITION OF FORMS

1. Instructions for completing Mental Health and Mental Retardation/Related Condition Evaluation Forms

These are step-by-step instructions detailing specific information needed for accurate completion of both evaluations.

2. Comprehensive Evaluation Forms: Mental Illness and Mental Retardation/Related Condition

The Level II evaluation is conducted as a result of an affirmative response to the Level I screening. Individuals with mental retardation/related condition will be evaluated on the mental retardation form. Individuals with mental illness will be evaluated on the mental illness form. Persons diagnosed with both mental illness and mental retardation will be evaluated on the appropriate sections of both forms. Generally, it is expected that all new applicants and subsequent reviews will receive a comprehensive evaluation, but there may be exceptions. The Comprehensive Medical History/Physical Examination form has been designed for the Centers' use if the required information is not available.

3. Verbal Determination form (MH evaluations only)

This form is to be used to communicate the PASRR determination with PRO prior to the completion of the comprehensive evaluation.

4. Response to Referral Form

This form is used to inform the referral source that the Level I screen was not indicative of the need for a Level II. This may occur when a referral is received and the person meets an exception, such as Alzheimer's disease or other dementia. It may also be used to explain why the Level II is not indicated, especially in cases where the referral diagnosis is found to be inaccurate by the CMHC.

5. PASRR Computer Summary Form

The PASRR Computer Summary form is used to collect the PASRR data keyed into the DMHMRS computer. This form must be completed and submitted to the DMHMRS whenever a Level II evaluation is completed. This form must be submitted for every comprehensive evaluation (new/pre-admission, initial/subsequent review, or current resident). It is very important that this form is completed accurately. For MR evaluations, do not submit the Computer Summary form to the Department until the letter is received informing of the determination of the Review Committee. The Department will use this form to generate program information for DMS and CMS reports. Consequently, Centers will not be required to submit a separate monthly report form. In addition, the form can be used to substantiate billing.

NOTE: THIS FORM IS SENT ONLY TO THE DMHMRS. DO NOT SEND COPIES TO THE NURSING FACILITY OR TO THE INDIVIDUAL BEING EVALUATED.

6. Cover Letters to Accompany Copies of Evaluations (see Appendices)

- Cover letter to be attached to copy of evaluation sent to the nursing facility applicant/legal representative.
- Cover letter to be attached to copies of Review of Findings sent to attending physician and discharging hospital (if applicable).

NOTE: Centers should use their own letterhead for cover letters, deleting the explanatory comments from the top of the page.

7. Explanation of Billing Form

Use this form to document PASRR MI/MR/related condition evaluations that exceed a total cost of Five Hundred Dollars (\$500.00) or for dually diagnosed evaluations that exceed Seven Hundred Fifty Dollars (\$750.00).

8. DMHMRS Billing Instructions for PASRR (see Appendices)

These forms, similar to the other CMHMRS billings, must be submitted to DMHMRS to request reimbursement for PASRR units.

9. Specialized Services Form (MI only)

This form is to be completed for all persons with mental illness who are recommended for specialized services. This form must be submitted to DMH with the comprehensive evaluation form.

10. Placement Options Form

This form designates options for long-term PASRR residents who meet thirty (30) month criteria and who have a diagnosis of mental illness, mental retardation, or related condition.

11. Medicaid Forms

See definitions on cover page.

SUBMITTAL OF EVALUATION FORMS TO DEPARTMENT

The procedures for submitting the PASRR information to the Department are as follows:

➞ FOR PERSONS WITH MENTAL ILLNESS:

Submit forms to: **PASRR Coordinator
Division of Mental Health
100 Fair Oaks Lane, 4E-D
Frankfort, KY 40621-0001**

1. Specialized services not recommended: Submit the PASRR Computer Summary form.
2. Specialized services recommended: Submit the entire PASRR/MI, the PASRR Computer Summary form, and the Specialized Services (Active Treatment) Identification form.

➞ FOR PERSONS WITH MENTAL RETARDATION:

Submit forms to: **PASRR Coordinator
Division of Mental Retardation
100 Fair Oaks Lane, 4W-C
Frankfort, KY 40621-0001**

1. Submit the entire PASRR/MR evaluation; including detailed history, physical information, and the psychological evaluation, if necessary.

➞ FOR PERSONS WITH DUAL DIAGNOSES:

Submit forms to: **PASRR Coordinator
Division of Mental Retardation
100 Fair Oaks Lane, 4W-C
Frankfort, KY 40621-0001**

1. Specialized services not recommended (MI): submit the PASRR Computer Summary form.
2. Specialized services recommended: the complete Level II evaluation for MR, the mental status/psychiatric assessment portion of the Level II evaluation for MI, the PASRR Computer Summary form, and the Active Treatment Identification form.

Do not submit the completed MI/MR PASRR evaluation for clients with a dual diagnosis to the Division of Mental Health.

Name _____

PASRR (LEVEL II) CHECKLIST (MI)

EVALUATION TIME FRAMES MET:

Date of Referral __/__/__
Date Verbal Given __/__/__
Date Report Sent __/__/__

IF NOT, IS:

_____ Letter of Explanation attached to Computer Summary Sheet?

EVALUATION PERFORMED BY APPROVED PERSONNEL:

___ PASRR certified evaluator or back-up evaluator
___ Physician's review and signature for medical/physical
___ *All sections of evaluation completed*

INDIVIDUAL/ GUARDIAN RIGHTS

___ Individual/Guardian signature obtained
___ Informed of appeal procedures

COMPLETE EVALUATION REPORT SENT TO:

___ Individual
___ Legal Guardian
___ Nursing Facility

COVER SHEET AND REVIEW OF FINDINGS SENT TO:

___ Attending physician
___ Discharging Hospital (if applicable)

IF SPECIALIZED SERVICES NEEDED:

___ Individual informed of community placement options including how, when, and by whom specialized services will be provided
___ Specialized services form and evaluation sent to DMHMRS
___ A board eligible psychiatrist counter signature obtained

TRIGGERED FOR SUBSEQUENT RESIDENT REVIEW (If appropriate) Yes___No___
If yes, date __/__/__ if no, documentation of closure in record Yes___No___

COMPUTER SUMMARY FORM SENT TO DMHMRS _____

INSTRUCTIONS FOR COMPLETING THE MENTAL HEALTH LEVEL II PASRR EVALUATION

<u>Page 1:</u>	Please see the MR instructions, as Page 1 is the same for both.	
<u>Page 2:</u>	<u>Psychiatric Hospitalization History:</u>	Please attempt to obtain this information. Part III, Page III-3 of the PASRR manual documents that a release of information is not needed for applicants applying to a Medicaid certified nursing facility. Consult with evaluators from other regions when evaluating someone from a different region as they might have a working relationship with the psychiatric facilities in their regions and be able to obtain this information for you. Interview family members and the applicant. If exact dates are not known, document approximated dates. Please make every attempt to obtain this information and to document it as this is needed to determine recent treatment.
	<u>Community Based Treatment:</u>	Interview the applicant and family members. Contact evaluators from other regions when indicated. Please document treatment in both the public and private sector, including outpatient and Community Support Services.
	<u>History of Cooperation:</u>	Please document this when known, although it frequently is not.
	<u>Referral Diagnosis:</u>	This should be the diagnosis that was given at the initial referral contact, not the diagnosis you arrive at based on the MSE or additional documentation. These might frequently be different.
	<u>Mental Status Assessment:</u>	Complete by indicating the appropriate option. If no appropriate options are listed, make note of this in the comments section. Please complete each category within a section and not place one check mark for the total section.
<u>Page 3:</u>	<u>Tools for MSE:</u>	Indicate at the top of Page 3 whether the Mini Folstein or another tool was used to complete the Mental Status evaluation.

	<u>Dementia/ Organicity:</u>	Note whether it is documented diagnosis or based on the MSE performed during the evaluation. If there is a documented diagnosis, but the results of the MSE performed for the evaluation do not substantiate this, comment on this line.
	<u>AXIS I:</u>	Indicate the current diagnosis believed to be correct based upon MSE and documentation. If there is a disparity between the diagnosis contained in attached documentation and the current correct diagnosis, please indicate this and why this is clinically indicated on the OTHER COMMENTS line.
	<u>AXIS II:</u>	As with the mental illness diagnosis, document the current clinically indicated diagnosis. Substantiate any disparity in diagnoses found in attached documentation and contained in the evaluative report. For mental retardation diagnoses, this will be Mental Retardation, level unspecified, unless there is available psychological testing, a diagnosis provided by a psychologist or psychiatrist, or reliable documentation that refers to a specific level of MR.
	<u>AXIS III:</u>	Document the currently active diagnoses first, and the historically related diagnosis last. Try to include all diagnoses if possible.
	<u>AXIS IV and AXIS V:</u>	<p>These may not always be relevant for PASRR purposes, but document these when possible. If unobtainable or not applicable, defer these diagnoses.</p> <p>›If dementia is substantiated as the primary diagnosis affecting the applicant's mental status, document this on the OTHER COMMENTS line and indicate that it is not necessary to complete additional components of the evaluation based on this impression.</p>
	<u>Medication History:</u>	Please list current medications and previous psychotropic medications. Please always include dosage frequency and reason. If a complete and current list of medications is attached, this (SEE ATTACHED MEDICATION LIST) may be noted on the line for CURRENTLY PRESCRIBED MEDICATIONS.
	<u>Previous Psychotropic Medications:</u>	List known medications prescribed in the past. Note that sometimes medications previously prescribed will be contained in medication allergies.

	<u>Mask or Mimic Psychosis:</u>	List medications currently prescribed that have potential to affect mental status by masking or mimicking psychosis/depression.
	<u>Self-Management:</u>	Check appropriate option. If individual is residing in a NF at the time of the evaluation and takes medications as offered, document Not Applicable in this component. Please complete for new admissions.
	<u>Side Effects:</u>	Note any physical indications of a drug induced movement disorder here. Also note complaints that the individual has that could be medication related.
	<u>Allergies:</u>	List allergies if available from documentation or individual's report. Document that information is unavailable if this should be the case.
	<u>Drug Abuse:</u>	Note abuse of alcohol and/or non-prescribed medication, if available. If not available from records or individual's report, document this.
<u>Page 4:</u>	<u>Reason For Placement:</u>	This is not specific nursing facility services that the individual will need, but the <u>reason</u> nursing facility placement is being requested. Please note that this section is requesting identification of changes in status and/or living situation that contributed to the request for placement.
	<u>Family and Friends:</u>	List family members and friends, especially those interviewed for the evaluation purpose. Include area codes with phone numbers. Please list names and relationship to the applicant.
	<u>Current Functioning Level:</u> <u>Communication Skills:</u>	Check the appropriate option. If impaired, note what action was taken to overcome this (i.e., communication board, physical cuing, changed vocal intonation, written communication, interpreter, etc.).

	<u>Support System:</u>	List agencies or people who have supported the individual or are currently a support source. This could include CMHC's, home health, Medicaid Waiver Program, friends, family, or other supports.
	<u>Rank Current Functioning:</u>	Indicate the functional level by assigning the appropriate number. If there is not an appropriate option or the option needs elaboration, document this on the line OTHER COMMENTS.
	<u>Impact of Physical/Medical on Functioning:</u>	Document how current medical diagnoses impact current functioning. This would also be the appropriate location to note previous functional abilities and compare functioning since physically ill.
Page 5:	<u>Describe Nursing Facility Services Needed or Receiving:</u>	Note the directive " Be very specific ". Possibilities include, but are not limited to; monitoring of vital signs (blood pressure, pulse, respiration), physical therapy, occupational therapy, speech therapy, respiratory therapy, administration and monitoring of medications, laboratory tests for various reasons, including medication levels, accurate diagnosing, monitoring of nutritional status, including recording of intake and output amounts or monitoring of a specialized diet, specific skin treatments, monitoring of indwelling or external catheter, gastric tube, IV site, wound healing, or other specific MD ordered treatment.
	<u>Comprehensive History and Physical Data: Source of Data:</u>	Refer to the specific document that was used as the basis for your determination of level of care. If there have been changes in the individual's condition since the document was completed, document the change in the appropriate body system component. If the document is complete and current you may refer to it by noting, "See attached document:.". If performing an evaluation in a medical setting and the discharge summary is not yet available, copy initial systems review and some recent physician progress notes, as the initial systems review often does not contain the current medical issues.
	<u>Abnormal Findings:</u>	Note abnormal findings that need further assessment or have potential to affect the individuals overall needs here.
	<u>Referral to Agency or Person:</u>	If referred to an outside agency for needed medical information, please note the agency or person here.

	<u>MDS Data:</u>	This is N/A for pre-admissions. If the individual is an initial resident review who was recently admitted, the MDS may not yet be completed, and this should be noted. If the individual has been in the facility for a longer period of time, the date of completion of the MDS is readily available by chart review.
	<u>Level of Care Certification:</u>	This is sometimes very difficult to obtain, and if this is the case, note, "Not obtained" on this line. This is N/A for all pre-admissions.
<u>Pages 6 and 7:</u>	Either refer to an attached document or arrange for completion by the professional who performed the systems review. Please note: the physical exam must be completed by a physician, registered nurse, or a physician's assistant. If not performed by a physician, he/she must review and concur with conclusions.	
<u>Page 8:</u>	<u>Review of Findings:</u>	<p>This is the summary that is forwarded to the individual's MD, so a brief but thorough summary is indicated for each component. Please do not leave any sections blank or reference another section of the evaluation. Documentation is required.</p> <p><u>Recommendations:</u> Check the appropriately indicated box.</p>
<u>Page 9:</u>	<u>Specialized Services Plan:</u>	Please complete this section or place N/A in the blank if it is not applicable.
	<u>Thirty-Month Option:</u>	This component is N/A unless specialized services are being recommended. The thirty (30) month period is calculated by counting back from the date of the first determination that NF level of care is not recommended.
	<u>Disposition:</u>	Check the appropriately indicated box.
	<u>Continue in Process:</u>	All individuals who have had Level II evaluations will continue in the process unless they have a primary diagnosis of dementia. If this is the case, document this here.

<u>Page 10:</u>	<u>Summary:</u>	Give a comprehensive account of information contained in the PASRR evaluation. Please note that this section requires a summary of complete findings, determination, and recommendations. Be very clear and specific.
<u>Page 11:</u>	<u>Time Frames:</u>	Note that the date referral received is the date that a decision was made that the referral requires a PASRR evaluation. The date verbal was given is the date a determination was made regarding level of care and specialized services and communicated to the nursing facility (usually the date of the mental status assessment). Date sent is the date the evaluation was mailed to the nursing facility.
<u>Page 12:</u>	<u>Interpretation of Findings:</u>	Indicate to whom the findings were sent by checking one of the three options. Be sure the evaluator signs this page.

**PASRR (Level II) Cover Sheet
Comprehensive Evaluation
For Mental Illness and Mental Retardation**

Date of Referral: _____

Date Assigned to PASSR Staff: _____

Name of Center Completing Assessment: _____

Applicant Identifying Data

Applicant's Name:		Social Security Number:	
Birth Date:	Sex:	Race:	Marital Status: Spouse:
Address:			
Current Living Arrangements:			
Legal Guardian:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please provide name and telephone number:
Are any ADA accommodations needed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, specify:			

Referral Information

Referral Source:	MAP 409 <input type="checkbox"/>	Telephone Contact: <input type="checkbox"/>	Subsequent Review (form or phone) <input type="checkbox"/>
Name:			
Relationship to Applicant:		Telephone Number:	
Facility Requested:			
(If known) Address:			
Contact Person:		Telephone Number:	
MD to receive summary of findings:		Name:	
		Address:	

Type of Referral: (Check One)

Mental Illness	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	Dual Diagnosis	<input type="checkbox"/>
		Related Condition	<input type="checkbox"/>	MI Portion Only	<input type="checkbox"/>
				MR Portion Only	<input type="checkbox"/>

Type of Assessment: (Check One)**Preadmission****Initial Resident Review**

<input type="checkbox"/> New Nursing Facility Applicant	<input type="checkbox"/> Hospital Exemption
(Did Not Meet Readmission Status)	<input type="checkbox"/> Provisional Admission
	<input type="checkbox"/> Delirium
	<input type="checkbox"/> Respite
	<input type="checkbox"/> New to PASSR

Subsequent Review

<input type="checkbox"/> Significant Changes in Condition	
---	--

Give Date of Nursing Facility Admission

--

Information for this evaluation was obtained from the following: (Identify person / agency and date of contact.)

<input type="checkbox"/> Applicant (If applicant was unable to significantly contribute to the interview, please identify reason):
<input type="checkbox"/> Family Members / Legal Representative:
<input type="checkbox"/> Other Agencies:
<input type="checkbox"/> Record / Document Review:

Name _____

Part 1: Comprehensive Evaluation - Mental Illness

A.	Mental Status / Psychiatric Assessment						
1.	Treatment Review						
	•	Psychiatric Hospitalization: Prior admission to state or private psychiatric facilities (give dates, facility and reason for admission)					
	•	Community-Based Treatment Involvement with community mental health center, private psychiatric or other treatment facilities (include outpatient and community support services)					
	•	History of cooperation with recommended treatment.					
2.	Referral / Diagnosis						
3.	Mental Status Assessment (other Mental Status Assessment tools may be utilized)						
Mental Status Assessment		Present		Mental Status Assessment		Present	
		Yes	No	Yes	No		
Appearance	Physically Unkempt, Unclean Clothing Disheveled, Dirty Clothing Atypical, Unusual, Bizarre Unusual Physical Characteristics	<input type="checkbox"/>	<input type="checkbox"/>	Orientation	Disoriented to Person Disoriented to Place Disoriented to Time	<input type="checkbox"/>	<input type="checkbox"/>
Posture	Slumped Rigid, Tense Atypical, Inappropriate	<input type="checkbox"/>	<input type="checkbox"/>	Memory	Impaired Immediate Recall Impaired Recent Memory Impaired Remote Memory	<input type="checkbox"/>	<input type="checkbox"/>
General Body Movements	Accelerated, Increased Speed Decreased, Slow Atypical, Peculiar, Inappropriate Restless, Fidgety	<input type="checkbox"/>	<input type="checkbox"/>	Perception	Illusions Auditory Hallucinations Visual Hallucinations Other Types of Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Facial Expression Suggests	Anxiety, Fear, Apprehension Depression, Sadness/Anger, Hostility Decreased Variability of Expression Bizarreness, Inappropriateness	<input type="checkbox"/>	<input type="checkbox"/>	Thought Content	Obsessions Compulsions Phobias Derealization, Depersonalization Suicidal Ideation Homicidal Ideation Delusions Paranoia Ideas of Reference Ideas of Influence	<input type="checkbox"/>	<input type="checkbox"/>
Amplitude And Quality of Speech	Increased, Loud Decreased, Slowed Atypical Quality, Slurring Stammering	<input type="checkbox"/>	<input type="checkbox"/>	Stream Thought (As manifested by speech) Feeling (Affect and mood)	Associational Disturbance Thought Flow Decreased, Slow Thought Flow Increased Inappropriate to Thought Content Increased Lability of Affect Predominate Mood is: - Blunted, Absent, Unvarying - Euphoric, Elated - Angry, Hostile - Fearful, Anxious, Apprehensive - Depressed, Sad	<input type="checkbox"/>	<input type="checkbox"/>
Response to Interview	Domineering Submissive, Overly Compliant Provocative Suspicious Uncooperative	<input type="checkbox"/>	<input type="checkbox"/>	Overt Behaviors	Abuses Substances Verbally Abuses Others Physically Abuses Others Destroys Property Physically Abuses Self Fearful, Crying, Clinging Takes Property from others without Permission Performs Repetitive Behaviors (Pacing, Rocking, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Functioning	Impaired Level of Consciousness Impaired Attention Span Impaired Abstract Thinking Impaired Calculation Ability Impaired Intelligence	<input type="checkbox"/>	<input type="checkbox"/>	Comments:			

Level II MI Evaluation

Page 2 of 12

Name: _____

Tools for mental status/psychiatric assessment:							
<input type="checkbox"/> Mini Folstein <input type="checkbox"/> Other, Please Specify:							
Is organicity/dementia present? <input type="checkbox"/> Yes <input type="checkbox"/> No How was this substantiated?							
4.	DSM IV Diagnostic Code & Label Impression based on clinical Data gathered. (provided by CMHMRC staff):						
	<table border="1"> <tr> <td>AXIS I</td> <td>AXIS IV</td> </tr> <tr> <td>AXIS II</td> <td>AXIS V</td> </tr> <tr> <td>AXIS III</td> <td></td> </tr> </table>	AXIS I	AXIS IV	AXIS II	AXIS V	AXIS III	
AXIS I	AXIS IV						
AXIS II	AXIS V						
AXIS III							
5.	Other Comments:						

**IF THE PERSON HAS A PRIMARY DIAGNOSIS OF ORGANIC MENTAL DISORDER
PASRR PROCESS STOPS HERE.**

(For the purposes of a PASRR evaluation, when a person has more than one diagnosis, the primary diagnosis is the one with the most pervasive symptoms or the condition that is chiefly responsible for the need for treatment. The primary diagnosis may not necessarily be listed first in a chronological listing of problems/conditions.)

Medication History (This section must be completed thoroughly)

1. Documentation of all medications individual has taken in the last year: (Identify below or attach medication list)

a. Currently prescribed

Medications	Dosage	Frequency	Reason

- b. Previous psychotropic medications (Please include dosage, frequency and reason):

- c. Comment on any medications that could mask or mimic mental illness symptoms.

2. Self-Management of medications (Please complete for new admission)

<input type="checkbox"/> Without Supervision	<input type="checkbox"/> Complies Only if Given Choice
<input type="checkbox"/> With Some Prompting and Supervision	<input type="checkbox"/> Hoards Medication
<input type="checkbox"/> Only With Prompting and Supervision	<input type="checkbox"/> Refuses Medication

3. Does client complain of side effects of medication or are there visible signs of side effects?

4. List all allergies including medication (prescribed or over the counter) allergies and food allergies.

5. Does the client use alcohol or other non-prescribed drugs? (Be sure to include wine or beer.) If yes, identify type, frequency, amount and length of use. Is there a history of alcohol abuse?

6. Other comments:

Name _____

C. Psychosocial Evaluation

1.	Reason for Placement: Identify those changes in the applicant's status and/or living situation that contributed to the request for nursing home placement.																				
2.	Family/Friends (list names & phone numbers:																				
3.	Current Functioning Level (ability of person to function in a less restrictive setting):																				
a.	Is the person's ability to communicate and verbalize in expressive/receptive skill areas impaired? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, please describe the Impairment and what action the evaluator took to overcome this?																				
b.	Support System:																				
c.	Please rank person's ability to perform in the following areas and/or identify current supports provided to assist with activity: <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>Rank current functioning:</div> <div> 1) Unable to Perform 3) Needs Minimum Assistance </div> <div> 2) Needs Moderate Assistance 4) Independent </div> </div> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 25%;">Activities of Daily Living (Rank)</th> <th style="width: 50%;">Instrumental Activities of Daily Living (Rank)</th> </tr> </thead> <tbody> <tr><td>Eating</td><td>Meal Preparation</td></tr> <tr><td>Dressing</td><td>Light Housekeeping</td></tr> <tr><td>Bathing</td><td>Heavy Housework</td></tr> <tr><td>Toileting</td><td>Money Management</td></tr> <tr><td>Grooming</td><td>Nutritional Habits</td></tr> <tr><td>Ambulation</td><td>Health Monitoring &</td></tr> <tr><td>Transfer</td><td>Medication Management</td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </tbody> </table>	Activities of Daily Living (Rank)	Instrumental Activities of Daily Living (Rank)	Eating	Meal Preparation	Dressing	Light Housekeeping	Bathing	Heavy Housework	Toileting	Money Management	Grooming	Nutritional Habits	Ambulation	Health Monitoring &	Transfer	Medication Management				
Activities of Daily Living (Rank)	Instrumental Activities of Daily Living (Rank)																				
Eating	Meal Preparation																				
Dressing	Light Housekeeping																				
Bathing	Heavy Housework																				
Toileting	Money Management																				
Grooming	Nutritional Habits																				
Ambulation	Health Monitoring &																				
Transfer	Medication Management																				
d.	Other Comments:																				
4.	Impact of physical/Medical Condition on functioning:																				

Name: _____

Medical History / Physical Examination

1. Describe the nursing facility services presently received, if resident, or recommended, if applicant. Be very specific.

2. Comprehensive History and Physical Data Available (Includes complete history and review of all body systems, specific evaluation of neurological system in area of motor and sensory functioning, gait, and deep tendon reflexes)

Nursing home admission cannot occur until after this requirement has been met. The examination must be performed by a physician, registered nurse or a physician assistant. If not performed by a physician, a physician must review and concur with the conditions.

- a. If information is available from facility record, MDS, hospitals or other sources, complete the following (and attach a copy of the medical history / physical exam):

1.	Source of Data:			
	Date Performed:		Performed By:	
2.	Major physical / medical needs:			
3.	Abnormal finding that requires additional information:			
	Finding	Evaluation Recommended	Date of Referral	To Agency / Person
	Comments:			

- b. If information is not available, evaluator or CMHC must either conduct the examination and complete the Comprehensive History and Physical Examination Form or refer the applicant to another office for the evaluation. If referred for evaluation, give:

Date of referral:		To Agency / Person:	
Date findings Returned:			
Summary of Major Physical / Medical Needs:			

3. Date of Last Minimum Data Set (MDS) Conducted at Facility (if appropriate):

--	--

 Note Major Physical Medical Needs:

--
4. Date of Last Level of Care Certification Performed by Peer Review (if appropriate):

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5. Other Comments:

--

Name: _____

Social Security Number: _____

Comprehensive Medical History / Physical Examination

The examination must be performed by a physician, registered nurse or a physician assistant. If not performed by a physician, he / she must review and concur with the conclusions. Information from a history / physical performed within the last year may be used if there has been no significant change in the individual's medical condition.

I. Medical History

E. History of Present Symptoms or Illness (include last date seen by physician, if applicable)	
E. Past Medical History (include physical or developmental disabilities and, if appropriate, pertinent family history)	
E. Allergies or Drug/Food Sensitivities	E. History of Substance Use/Abuse, Frequency, Amount (include alcohol)

II. Review of Body Systems - Assess all variables and explain all abnormal findings.

Vital signs:	T:	P:	R:	B/P:	HT:	WT:
---------------------	-----------	-----------	-----------	-------------	------------	------------

General Appearance and Behavior:
Skin:
Head:
Face (include Eyes, Ears, Nose):
Mouth, Throat, Neck:
Cardiovascular:
Pulmonary:

Name: _____

Social Security Number: _____

Breast:

Gastrointestinal:

Genitourinary:

Rectal:

Musculoskeletal:

Neurological (include Motor Functioning, Sensory Functioning, Gait, Deep Tendon Reflexes, Cranial Nerves and abnormal reflexes):

- III. Abnormal Findings - In case of abnormal findings, which are the basis for the individual's nursing home placement, include recommendations for additional information.

--

- IV. Summary of Major Medical/Physical Needs.

--

Signature and Professional Title (RN or PA) if not performed by a physician

Date

Physician Signature (A physician must sign here in order to complete the form)

Date

Name: _____

Part II: Findings and Recommendations**A. Review of Findings**

•	Positive Traits/Developmental Strengths and Weaknesses:
•	Medication History:
•	Mental Status/Psychiatric Assessment (include dangerousness to self or others):
•	Psychosocial Evaluation:
•	Medical History/Physical Examination:
•	Impact of Physical/Medical Condition on functioning:
•	Nursing Facility Care Needs:
•	Generic Mental Health Services Recommended (Clearly describe mental health services needed and how they will benefit the resident.):

B. Recommendations

1. Does person need nursing facility care? (Check one) ☐ Yes ☐ No
2. Are Specialized Services recommended? (Check one) ☐ Yes ☐ No

(If yes, Specialized Services Identification Form, this complete evaluation and the Computer Summary Form must be sent to the Division of Mental Health.)

Name: _____

C. Specialized Services (Active Treatment) Plan(Attach Other Information if Necessary):

Specialized Services (Active treatment) Definition for Mental Illness: Specialized Services is the implementation of an individualized plan of care developed under and supervised by a physician, and provided by an interdisciplinary team of qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of serious mental illness, which necessitates continuous supervision by trained mental health personnel. An applicant with mental illness who requires specialized services shall be considered to be eligible for the level of services provided in an institution for mental disease (IMD) or an inpatient psychiatric hospital.

D. Thirty (30) Months Placement

A nursing facility resident is considered a long term resident if he/she has resided in a nursing facility for more than (30) months from the date of the first resident review that determined he/she was not in need of nursing facility services. A long term resident, as defined, may continue to reside in a nursing facility if he/she requires specialized services. If specialized services are recommended, please check one:

- ☐ Person has resided in the facility for more than 30 months and requests specialized services in:
- ☐ in the facility, or
 - ☐ in the community.
- ☐ Person has resided in the facility for less than 30 months. Specialized services may not be provided in the facility.

E. Disposition - Check one only. This information must be consistent with the disposition on the PASRR Computer Summary. For assistance, refer to the PASRR Manual.

- **Admission To or Continued Stay in Nursing Facility**

- ☐ No specialized services recommended
- ☐ Specialized services recommended
- ☐ Client declined specialized services

- **Not Admitted to Nursing Facility or does not need Nursing Facility Care**

- ☐ Recommended to state treatment facility / CMHMRC program
- ☐ Recommended to private treatment facility / community program
- ☐ No action taken

- ☐ Admitted to or continued stay in State IMD
- ☐ Inappropriate PASRR Referral; Meets Exemption -- Process Stops

Does the individual continue in the PASRR process? ☐ Yes ☐ No If no, PASRR process ends. Please explain

Name:

Summary Report: Based upon the comprehensive analysis of all data gathered concerning the applicant/ resident, provide a clear and succinct summary of the findings, determinations and recommendations. This summary should give a clear picture of the applicant's / resident's current functional status, describe their treatment and service needs, and identify the most appropriate setting where these services should be provided.

G. EVALUATION TIME FRAMES

Date of Referral _____ Date Verbal Given _____ Date Report Sent _____

H. SIGNATURE OF EVALUATOR: _____

TITLE: _____ **DATE:** _____

COUNTER SIGNATURE: _____

TITLE: _____ **DATE:** _____

SIGNATURE OF EVALUATOR: _____

TITLE: _____ **DATE:** _____

COUNTER SIGNATURE: _____

TITLE: _____ **DATE:** _____

The following conditions will warrant a countersignature: (1) If the applicant/resident requires active treatment for mental illness, then a Board-eligible Psychiatrist must sign the evaluation; (2) if a mental health associate completes the assessment, then the supervising professional staff (as designated in the KMAP) must sign the evaluation; and (3) if a history and physical are not performed by a physician, a physician must review and concur with the conclusions.

If other evaluators were responsible for particular sections, please include below:

_____ Mental Status/Psychiatric Assessment	_____ Medication History
_____ Name & Title	_____ Name & Title
_____ Date	_____ Date
_____ Psychological Evaluation	_____ Medical History/Physical Examination
_____ Name & Title	_____ Name & Title
_____ Date	_____ Date

GLOSSARY OF TERMINOLOGY AND
INSTRUCTIONS FOR COMPLETION OF LEVEL II
Mental Retardation/Related Condition

<u>Page 1:</u>	The following are options for completing specified portions of Page 1 of the Level II PASRR evaluation. Instructions are also noted.	
	Applicant's Name:	First name first.
	Race:	White African American American Indian Asian Alaskan Native Native Hawaiian/Pacific Islander Hispanic
	Marital Status:	Single/Never Married Married Divorced Co-habiting Widowed Separated Unknown
	Current Living Arrangements:	Indicate the location of the individual at the point of interview or contact.
	Legal Guardian:	A Court appointed full guardian. This would not include POA's, financial representatives, etc. It is acceptable to list other representatives, but specify the relationship to the applicant.
	ADA Accommodations:	Americans with Disabilities Act. This would include adaptive devices interpreters, or any assistive devices needed to perform the evaluation.
	Referral Information:	Include area codes with phone numbers.
	Type of Referral:	This should be consistent on all evaluations. However, there are instances when dually diagnosed residents require an update for only one diagnosis. Please indicate which by checking the appropriate box.

Type of referral:	<u>Mental Illness:</u>	An individual who meets the criteria on the MAP-409 for a serious mental illness.
	<u>Mental Retardation:</u>	An individual who meets the criteria on the MAP-409 for mental retardation. Note that IQ testing may not be available in all cases, but a history validated by an acquaintance may also be indicative of MR. The CMHMRC has the ultimate authority in validation of mental retardation, either by phone contact or face-to-face contact.
	<u>Related Condition:</u>	A condition similar to mental retardation usually caused by a developmental delay during childhood (prior to age 22). See the MAP-409 for conditions that might be indicative of a related condition. Note that the individual would meet criteria for substantial functional limitations in three or more of the listed major life activities prior to age 22.
	<u>Dual Diagnosis:</u>	An applicant or resident who meets the criteria for both mental illness and mental retardation or related condition as identified on the MAP-409.
	<u>New Admission:</u>	An individual is a new admission of he/she is admitted to any NF for the first time or does not qualify as a re-admission. With the exception of certain hospital discharges described herein, all new admissions are subject to Level I screening.
	<u>Re-Admission:</u>	An individual is a re-admission of he/she was re-admitted to a NF from a hospital to which he/she was transferred for the purpose of receiving care. Re-admissions are not subject to Level I screening, but may be subject to a Subsequent Review if the person has experienced a significant change in condition as defined in 3.44 of this manual.

	<u>Hospital Exemption:</u>	An individual who currently resides in a hospital whose physician has completed the thirty (30) day exemption form stating that nursing facility is needed for management of the problem for which the individual was hospitalized. This stay is expected to be thirty (30) days or less. Do not allow thirty (30) day exemptions for those individuals who clearly will require more than thirty (30) days of NF services.
	<u>Provisional Admissions:</u>	<p>A request for a Level II PASRR should be initiated when it appears that the individual admitted under this provisional admission will not be discharged within the fourteen (14) days. The nursing facility will not be eligible for reimbursement after the fourteenth (14th) day of the admission date until a PASRR determination is made authorizing nursing facility level of care. There are two (2) categories of provisional admissions.</p> <ul style="list-style-type: none"> ‣ <i>Delirium:</i> An individual who is experiencing an episode of delirium related to a physical condition that is expected to resolve within fourteen (14) days. ‣ <i>Respite:</i> An individual whose caregiver has requested admission to a NF for not more than two (2) weeks (fourteen (14) days) of relief from caregiver responsibility.
	<u>New to PASRR:</u>	An individual who resides in a nursing facility but has not previously had a Level II performed. This is usually someone who was admitted without adequate information to document the existence of a mental illness or mental retardation/related condition diagnosis prior to admission.

	<u>Initial Resident Review:</u>	An individual who was admitted to the nursing facility without a Level II having been performed prior to admission. This could include a hospital exemption, one of the provisional categories (delirium and respite), or an individual who did not appear to meet criteria upon admission, but new information becomes available or circumstances change.
	<u>Significant Change of Condition:</u>	A current resident of a NF (who has previously had a Level II evaluation) and experiences a change in physical or mental functioning that will affect that individual's need for either continued nursing facility stay as the least restrictive environment, or might now need specialized services and previously did not.
	<u>Subsequent Review:</u>	Significant change in condition line should be documented as the date the MDS triggered a significant change. <u>The date of admission to the nursing facility is the initial admission date to the facility.</u>
	<u>Informational Sources:</u>	Directions for this component are fairly self-explanatory. It should be noted; however, that under record/document review that when previous Level II evaluations are used as an informational resource, this should be documented here.
<u>Page 2:</u>	<u>Name:</u>	First name first.
	<u>Date Completed:</u>	Date of face-to-face or direct contact with the individual.
	<u>Identified Condition:</u>	Note AXIS II diagnosis here. If there is no specifically identified level of MR from testing, this will be Mental Retardation, level unspecified.

	<u>Validation of MR:</u>	If there is accessible testing available, identify the name title of the examiner, along with the date of the testing here in Part A, #2. If there is no accessible testing, list the information (verbal from a knowledgeable source or a diagnosis contained in a CHMC treatment record, etc.) used to validate the diagnosis in this section. If the individual has a related condition, note the specific related condition here.
	<u>Age of Onset:</u>	May occur anywhere on a time line from birth to age 22 for related conditions. List this in Column A, #3.
	<u>Additional Comments:</u>	Please describe the individual's response to your interview and interaction in Column B.
<u>Page 3:</u> <u>Part B1:</u>	<u>Medical Problems:</u>	List medical problems that are current. If an individual has a history of a disorder that is currently stable and not an active problem, note this in Column B, impact on functioning. Likewise, if the problem is active, note the degree this particular problem affects this individual's functioning.
<u>Part B2a:</u>	<u>Medications:</u>	List medications here. Do not document "see attached list" on this section.
<u>Part B2b:</u>	<u>Response to Medication Groups:</u>	If available by the individual's report or recorded in their record, list current and past reactions to medications from these drug groups.
<u>Page 4 –</u> <u>Page 5:</u>	<u>Part B, #3, Column A:</u>	Continue medication list (if necessary) here.
	<u>Column B:</u>	Record to what extent the individual is able to participate in provision of their medical needs.

	<u>Part C, Developmental Needs and Services: Column A:</u>	<p>List strengths and weaknesses identified in each component.</p> <p>When identifying individual's strengths and needs, please be specific. Blanket statements such as "total care" are not only non-descriptive, but do not supply the Committee with enough information to make an informed determination as to the individual's needs.</p>
	<u>C1: Self Help Development:</u>	Be specific regarding the level of assistance required. When possible, note level of ability at baseline functioning.
	<u>C2: Sensorimotor Development:</u>	Document as specifically as possible. Committee needs a mental picture of how mobile the individual is. As previously noted, when information about previous functional level is available, document this, also.
	<u>C3: Speech and Language:</u>	Note whether the individual has ever spoken, if currently non-communicative. If it appears the individual has good receptive communication (i.e., responds appropriately to interview), document this. This component is important for understanding how aware the individual is of his or her surroundings.
	<u>C4: Social Development:</u>	Document to what extent the individual seeks out interaction. Document activities enjoyed and/or disliked.
	<u>C5: Academic/ Educational:</u>	Approximate grade in school individual completed. Note whether individual is literate. If known, document why schooling was not sought or was stopped.
	<u>C6: Independent Living Skills:</u>	Address each of the skills listed if information is available. This component also is a good indicator of self-awareness.

	<u>C7: Vocational Development:</u>	It is very important to document any workshops or supervised work settings the individual has attended. If the individual communicates, inquire about work history. This is usually a source of pride, and most will report working in the garden, tobacco fields, or on the farm. If the individual seems capable, inquire about his or her interest in working.
	<u>C8: Affective Development:</u>	Document to what extent the individual is involved in making day-to-day and life decisions.
	<u>C9: Maladaptive Behaviors:</u>	This is a very important component. If the individual is unable to communicate, please inquire with caregivers. A question that might be appropriate is "Does she or he get along well with others?" Another example is "Does he or she ever do anything harmful to themselves or others?"
	<u>Column B:</u>	Recommend services identified to meet the listed codes. This column should either contain a needed service (generic or specialized), or an indication that no specific services are needed.
<u>Page 6:</u>	<u>Describe NF Services Received or Recommended:</u>	See the directive "Be very specific." Possibilities include, but are not limited to, monitoring of vital signs (blood pressure, pulse, respirations), physical therapy, occupational therapy, speech therapy, respiratory therapy, administration and monitoring of medications, laboratory tests for various reasons, including medication levels, and accurate diagnosing, monitoring of nutritional status including recording of intake and output amounts or monitoring of a specialized diet, specific skin treatments, monitoring of Foley catheter, gastric tube, IV site, or wound healing, or other specific MD ordered treatment.

<u>Comprehensive H and P:</u>	<u>Source of Data:</u>	Specify either an attached document (i.e., history and physical or progress note), or systems review performed by a staff member. If performing an evaluation in a medical setting and discharge summary is not yet available, copy initial admission systems review and some recent physician progress notes, as the initial systems review often does not contain the current and complete medical issues.
	<u>Major Physical/Medical Needs:</u>	Document these here, or if they are contained in a document, you may refer to the specific document. (See history and physical.)
	<u>Abnormal Findings:</u>	Note abnormal findings that need further assessment or have potential to affect the individual's overall needs here.
	<u>Referral to Agency or Person:</u>	If referred to an outside agency for needed medical information, please note the agency or person here.
	<u>MDS Data:</u>	This is N/A for most pre-admissions. If the individual is a subsequent review who was recently admitted, the MDS may not yet be completed, and this should be noted. If the individual has been in the facility for a longer period of time, the date of completion of the MDS is readily available by chart review.
	<u>Level of Care Certification:</u>	This is sometimes very difficult to obtain, and if this is the case, note, "Not obtained" on this line. This is N/A for all pre-admissions.
<u>Page 7 – Page 8:</u>	<u>Comprehensive Medical History/Physical Examination:</u>	If the document referred to for this is current, you may refer to that document by indication, "See the attached document". If there are changes noted since the referenced document, please note the changes in the appropriate component.

<u>Page 9:</u>	<u>Summary of Findings:</u>	<p>Briefly summarize the noted components. This is the summary that is forwarded to the individual's MD, so a brief, but thorough, summary is indicated.</p> <p>Recommendations: Check the appropriately indicated box.</p>
<u>Page 10:</u>	<u>30-Month Placement Option:</u>	<p>This component is N/A unless specialized services are being recommended. The thirty (30) month period is calculated by counting back from the date of the first determination that NF level of care is not recommended. The thirty (30) month option form should be forwarded to those individual's who have resided in the NF for thirty (30) months prior to this determination.</p>
	<u>Disposition:</u>	Check the appropriately indicated box.
	<u>Not Admitted to NF:</u>	Indicate the CMHC clinician or the agency and person to whom the individual was referred to receive alternate services from.
<u>Page 11:</u>	If there is more than one nursing facility admission, please refer to these admissions in this comprehensive summary.	
<u>Page 12:</u>	<u>Time Frames:</u>	<p>Date of referral is the date the evaluation was deemed necessary. Date verbal given is the date the PASRR Review Committee letter was received (by facsimile transmittal) in the PASRR office. Date report sent is the date the written evaluation was forwarded to the nursing facility.</p>
<u>Page 13:</u>	Contains a description of specialized services. Compare the abilities of the individual being evaluated with the criteria on Page 13, listed from 1-8. If most of these can be answered "yes", this individual may likely require some type of specialized service.	
<u>Page 14:</u>	Please indicate to which party the interpretation of findings was sent to by selecting the appropriate choice. Be sure the evaluator who performed the evaluation signs the interpretation of findings.	

Name _____

PASRR (LEVEL II) CHECKLIST (MR)

EVALUATION TIME FRAMES MET:

Date of Referral: ___/___/___
Date Verbal Given: ___/___/___
Date Report Sent: ___/___/___

IF NOT, IS:

_____ Letter of Explanation attached to Computer Summary Sheet?

EVALUATION PERFORMED BY APPROVED PERSONNEL:

_____ PASRR certified evaluator or back-up evaluator
_____ Physician's review and signature for medical/physical
_____ Psychological evaluation for mental retardation
_____ *All sections of evaluation completed*

INDIVIDUAL/GUARDIAN RIGHTS

_____ Individual/Guardian signature obtained
_____ Informed of appeal procedures

COMPLETE EVALUATION REPORT SENT TO:

_____ Individual
_____ Legal Guardian (If applicable)
_____ Nursing Facility

COVER SHEET AND REVIEW OF FINDINGS SENT TO:

_____ Attending Physician
_____ Discharging Hospital (if applicable)

IF SPECIALIZED SERVICES RECOMMENDED:

_____ Evaluation sent to DMHMRS for review by PASRR Committee
_____ If mental retardation, licensed psychologist counter signature obtained.
_____ If mental illness, board eligible psychiatrist counter signature obtained.
* **[Special Instructions for MR (see IV, 4.7)]**

COMPUTER SUMMARY FORM SENT TO DMHMRS _____

**PASRR (Level II) Cover Sheet
Comprehensive Evaluation
For Mental Illness and Mental Retardation**

Date of Referral: _____

Date Assigned to PASSR Staff: _____

Name of Center Completing Assessment: _____

Applicant Identifying Data

	Applicant's Name:		Social Security Number:	
	Birth Date:		Sex:	
			Race:	
	Address:			
	Current Living Arrangements:			
	Legal Guardian:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please provide name and telephone number:
	Are any ADA accommodations needed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	If yes, specify:			

Referral Information

	Referral Source:	MAP 409 <input type="checkbox"/>	Telephone Contact: <input type="checkbox"/>	Subsequent Review (form or phone) <input type="checkbox"/>
	Name:			
	Relationship to Applicant:	Telephone Number:		
	Facility Requested:			
	(If known) Address:			
	Contact Person:		Telephone Number:	
	MD to receive summary of findings:	Name:		
		Address:		

Type of Referral: (Check One)

	Mental Illness	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	Dual Diagnosis	<input type="checkbox"/>
			Related Condition	<input type="checkbox"/>	MI Portion Only	<input type="checkbox"/>
					MR Portion Only	<input type="checkbox"/>

Type of Assessment: (Check One)**Preadmission****Initial Resident Review**

<input type="checkbox"/>	New Nursing Facility Applicant	
	(Did Not Meet Readmission Status)	
		<input type="checkbox"/> Hospital Exemption
		<input type="checkbox"/> Provisional Admission
		<input type="checkbox"/> Delirium
		<input type="checkbox"/> Respite
		<input type="checkbox"/> New to PASSR

Subsequent Review

<input type="checkbox"/>	Significant Changes in Condition	
--------------------------	----------------------------------	--

Give Date of Nursing Facility Admission

--	--	--

Information for this evaluation was obtained from the following: (Identify person / agency and date of contact.)

<input type="checkbox"/>	Applicant (If applicant was unable to significantly contribute to the interview, please identify reason):
<input type="checkbox"/>	Family Members / Legal Representative:
<input type="checkbox"/>	Other Agencies:
<input type="checkbox"/>	Record / Document Review:

This evaluation may be typed or hand written legibly in ink.

PASRR Level II Comprehensive Evaluation for Mental Retardation (PASRR 2/MR)

Name: _____

SS # _____

Referral Date: _____

Date Completed: _____

Evaluated or Reviewed by (include name, title and date): _____

PART A Diagnosis	A. Identified Condition DSM - IV	B. Additional Comments
1. Identification of intellectual functioning measurement		
2. Validation of MR / Related condition (attach copy of Psychological evaluation and report); if applicable		
3. Identify age of onset		

PART B Medical		A. List of Medical Problems and Medications	B. Impact of Health Problems On Independent Functioning
1.	List of the medical problems		
2.	a. List of current medications (include frequency)		
	b. Response to following prescribed drug groups:		
	1) Hypnotics 2) Antipsychotics 3) Mood Stabilizers Antidepressants 4) Anti-anxiety 5) Anti Parkinson		

Name:

Region:

Evaluated or Reviewed by (include name, title and date): _____

PART B Medical (continued)	A. List of Medical Problems and Medications	B. Impact of Health Problems On Independent Functioning
3. Ability of the individual to monitor: a. Health status b. Medical treatments (i.e. medication) c. Nutritional Status		
PART C Developmental Needs / Services	A. Developmental Strengths and Needs	B. Recommendation of Services to Meet Identified Needs
1. Self-help Development (toileting, dressing, eating and grooming)		
2. Sensorimotor Development (ambulation, positioning transfer skills): gross and fine motor dexterity, visual motor perception, eye-hand coordination) To what extent could corrective devices improve the individual's functional capacity?		
3. Speech and Language Development (communication, receptive language, use of communication aids)		
4. Social Development (interpersonal skills, recreation / leisure skills)		

Name: _____ Region: _____
 Evaluated or Reviewed by (include name, title and date): _____

PART C Developmental Needs / Services (continued)	A. Developmental Strengths and Needs	B. Recommendation of Services to Meet Identified Needs
5. Academic / Educational Development (including functional learning)		
6. Independent Living (level of supervision, meal preparation, financial, community, mobility skills, housekeeping, etc.)		
7. Vocational Development (include present skills, employability)		
8. Affective Development (skills involved with making judgments and independent decisions expressing emotions)		
9. Maladaptive or inappropriate behaviors (frequency and intensity)		

Name: _____

Medical History / Physical Examination

1. Describe the nursing facility services presently received, if resident, or recommended, if applicant. Be very specific.
2. Comprehensive History and Physical Data Available (Includes complete history and review of all body systems, specific evaluation of neurological system in area of motor and sensory functioning, gait, and deep tendon reflexes)

Nursing home admission cannot occur until after this requirement has been met. The examination must be performed by a physician, registered nurse or a physician assistant. If not performed by a physician, a physician must review and concur with the conditions.

a.	If information is available from facility record, MDS, hospitals or other sources, complete the following (<i>and attach a copy of the medical history / physical exam</i>):			
1.	Source of Data: _____			
	Date Performed: _____		Performed By: _____	
2.	Major physical / medical needs:			
3.	Abnormal finding that requires additional information:			
	Finding	Evaluation Recommended	Date of Referral	To Agency / Person
	Comments:			
b.	If information is not available, evaluator or CMHC must either conduct the examination and complete the Comprehensive History and Physical Examination Form or refer the applicant to another office for the evaluation. If referred for evaluation, give:			
	Date of referral: _____		To Agency / Person: _____	
	Date findings Returned: _____			
	Summary of Major Physical / Medical Needs:			
3.	Date of Last Minimum Data Set (MDS) Conducted at Facility (if appropriate):			
	Note Major Physical Medical Needs:			
4.	Date of Last Level of Care Certification Performed by Peer Review (if appropriate):			
5.	Other Comments:			

PASRR/2/MR

 Name: _____
 Social Security Number: _____

Comprehensive Medical History / Physical Examination

The examination must be performed by a physician, registered nurse or a physician assistant. If not performed by a physician, he / she must review and concur with the conclusions. Information from a history / physical performed within the last year may be used if there has been no significant change in the individual's medical condition.

I. Medical History

1. History of Present Symptoms or Illness (include last date seen by physician, if applicable)	
2. Past Medical History (include physical or developmental disabilities and, if appropriate, pertinent family history)	
3. Allergies or Drug/Food Sensitivities	4. History of Substance Use/Abuse, Frequency, Amount (include alcohol)

II.

Review of Body Systems - Assess all variables and explain all abnormal findings.						
Vital signs:	T:	P:	R:	B/P:	HT:	WT:
General Appearance and Behavior:						
Skin:						
Head:						
Face (include Eyes, Ears, Nose):						
Mouth, Throat, Neck:						
Cardiovascular:						
Pulmonary:						

PASRR/2/MR

Name: _____
 Social Security Number: _____

Breast:
Gastrointestinal:
Genitourinary:
Rectal:
Musculoskeletal:
Neurological (include Motor Functioning, Sensory Functioning, Gait, Deep Tendon Reflexes, Cranial Nerves and abnormal reflexes):

- III. Abnormal Findings - In case of abnormal findings, which are the basis for the individual's nursing home placement, include recommendations for additional information.

--

- IV. Summary of Major Medical/Physical Needs.

--

Signature and Professional Title (RN or PA) if not performed by a physician	Date
Physician Signature (A physician must sign here in order to complete the form)	Date

PASRR/2/MR

Name: _____

Review of Findings

- **Psychological Evaluation (validation of MR or related condition):**
- **Medical Diagnosis and history (List ICD-9 codes if available from hospital or nursing home):**
- **Medications:**
- **Nursing Facility Care Needs:**
- **Developmental Strengths/Needs:**

Recommendations

- **Does person require nursing facility placement for medical needs that cannot be provided for in less restrictive setting e.g., IFC/MR or community placement?**
Yes ☐ No ☐
- **Are specialized services (active treatment) recommended? Yes ☐ No ☐ If yes, the completed evaluation must be sent to the Division of Mental Retardation for a determination by the DMHMRS PASSR Committee.**

Specialized Services Recommended

PASRR/2/MR

Name: _____

Specialized Services (Active Treatment) Definition for Mental Retardation

Specialized services for mental retardation is very broadly defined as any service or support an individual needs which is beyond the scope of the nursing facility to provide. These needs are described in the "Developmental Strengths and Needs" Column (Column B) of the MR comprehensive evaluation form. Recommendations to meet these needs are made in Column C. Examples of needed supports and services are: a day habilitation program; an augmentative communication device; An evaluation to determine the need for a particular therapy, or a therapy which would be strictly habilitative in nature. The responsibility of the PASRR evaluator is to use his / her expertise as a QMRP to recognize these needs and make the recommendation. The final determination rests with the Department for Mental Health / Mental Retardation Services PASRR Review Committee (See Section 4.6).

NOTE: Once the final determination is made that specialized services are needed, the individual's name will be placed on a list, the center MR / DD director will be notified, and when the funding mechanism is in place, a case manager will be assigned, and a person – centered planning process will be initiated to assure the individual receives identified services.

30 – Months Placement

A nursing facility resident is considered a long term resident if he / she has resided in a nursing facility for more than 30 months from the date of the first resident review that determined he / she was not in need of nursing facility services. A long term resident, as defined, may continue to reside in a nursing facility if he / she requires specialized services. If specialized services are recommended, please check one:

- ☐ Person has resided in the facility for more than 30 months and requests specialized services in the facility.
- ☐ Person has resided in the facility for less than 30 months. The DMR must provide or arrange for the provision of specialized services in a community placement. The person may remain in the nursing facility until such services and supports are in place.

Disposition

Check one only. This information must be consistent with the disposition on the PASRR Computer Summary. For assistance, refer to the PASRR Manual.

- Admission to or Continued Stay in Nursing Facility
 - ☐ No specialized services recommended
 - ☐ Specialized services recommended
 - ☐ Client declined specialized services
- Not Admitted to Nursing Facility →

Has referral been made for alternative services
☐ Yes ☐ No

Name of clinician:	
Phone number:	
Date of referral:	

- ☐ Recommended to state treatment facility / CMHMRC program
- ☐ Recommended to private treatment facility / community program
- ☐ No action taken
- Admitted to or continued stay in State IMD
- Inappropriate PASRR Referral; Meets Exemption – Process Stops

[illegible]

PASRR/2/MR

Name: _____

Evaluation Time Frames

Date of Referral: _____ Date Verbal Given: _____ Date Report Sent: _____

Signature of Evaluator: _____

Title: _____ Date: _____

Counter Signature: _____

Title: _____ Date: _____

Signature of Evaluator: _____

Title: _____ Date: _____

Counter Signature: _____

Title: _____ Date: _____

The following conditions will warrant a counter signature: (1) If the applicant / resident requires specialized services for mental retardation, then a licensed psychologist must sign the evaluation; and (2) if a history and physical are not performed by a physician, a physician must review and concur with the conclusions.

If other evaluators were responsible for particular sections, please include below:

☐ Medication History

Name and Title Date

☐ Psychological Exam

Name and Title Date

☐ Medical History / Physical Examination

Name and Title Date

PASRR/2/MR

Name: _____ Region: _____

Part D: Specialized Services and Nursing Facility Placement RecommendationsPre-admission Screening: ☐

The PASRR / MR process must review the data collected and identify to what extent the person's status compares with each of the following characteristics, commonly associated with need for specialized services (active treatment).

If the person has the inability to:

1. Take care of most personal care needs;
2. Understand simple commands;
3. Communicate basic needs and wants;
4. Be employed at a productive wage level without systematic long term supervision or support;
5. Learn new skills without aggressive and consistent training;
6. Apply skills learned in a training situation to other environments or place without direct aggressive and consistent training;
7. Demonstrate behavior appropriate to the time, situation or place without direct supervision;
8. Make decisions requiring informed consent without extreme difficulty; or

Demonstrates severe maladaptive behavior(s) that place the person or others in jeopardy to health and safety; and / or

Has other skill deficits or specialized training needs that necessitate the availability of trained MR personnel, 24 hours per day, to teach the person functional skills.

THEN the need for specialized services is strongly indicated.

Specialized services for mental retardation is very broadly defined as any service or support an individual needs which is beyond the scope of the nursing facility to provide. These needs are described in the "Developmental Strengths and Needs" Column (Column B) of the MR comprehensive evaluation form. Recommendations to meet these needs are made in Column C. Examples of needed supports and services are: a day habilitation program; an augmentative communication device; An evaluation to determine the need for a particular therapy, or a therapy which would be strictly habilitative in nature. The responsibility of the PASRR evaluator is to use his / her expertise as a QMRP to recognize these needs and make the recommendation. The final determination rests with the Department for Mental Health / Mental Retardation Services PASRR Review Committee (See Section 4.6).

NOTE: Once the final determination is made that specialized services are needed, the individual's name will be placed on a list, the center MR / DD director will be notified, and when the funding mechanism is in place, a case manager will be assigned, and a person - centered planning process will be initiated to assure the individual receives identified services.

Specialized Services (Active Treatment) Recommended: yes ☐ no ☐

Residence of more than 30 months: yes ☐ no ☐

Signature _____

Title _____

PASRR/2/MR

Name: _____

INTERPRETATION OF PASRR FINDINGS: The Center for Medicare and Medicaid Services (CMS) regulations mandate that the findings of this evaluation be interpreted and explained to the individual and, where applicable, to a legal representative designated under state law.

The findings of this evaluation have been explained to (check one):

- ☐ individual
- ☐ legal representative

I understand that my signature does not mean that I consent to or agree with the findings, but only that the evaluation has been received by me and the first-level hearing rights have been explained to me should I disagree with the determination and wish to appeal.

NOTE: If signature was not obtained, please document steps taken to obtain signature and note the date that the Interpretation of Findings were sent to the individual / representative.

Individual / Representative

(Relationship, if appropriate)

Mental Health / Mental Retardation Board Staff _____

Title _____

Date _____

VERBAL DETERMINATION FORM

CLIENT NAME _____

SOCIAL SECURITY NO: _____--____--_____

BIRTHDATE: ____/____/____ DATE: _____

Referral Source: _____

Nursing Home Requested: _____

Diagnosis: _____

The Department for Mental Health/Mental Retardation Services (DMHMRS) and/or its designee (PASRR evaluator) has reviewed the Level II evaluation information and has made the following determination(s)/recommendation(s):

The applicant is appropriate for admission to a nursing facility.

_____ Yes _____ No

The current resident of the nursing facility continues to need the level of nursing care received in the nursing facility. _____ Yes _____ No

The current resident requires specialized services. _____ Yes _____ No

The complete evaluation and determination information will be provided and forwarded to the applicant/resident and/or his legal representative, the nursing facility, and other appropriate persons.

NOTE: A verbal determination is not given for persons with MR/related condition until the Review Committee has made its determination.

PASRR Evaluator: _____

PASRR Coordinator: _____

PASRR

RESPONSE TO REFERRAL

To: _____

From: _____

Date: _____

SUBJECT: Pre-admission Screening and Subsequent Review (PASRR)

Individual's Name: _____

Facility or Referral Source: _____

Applicant/Resident: _____

ID#: _____

On _____, this agency received a request for a Level II PASRR evaluation on the above-named person.

Referral Information: _____

Reason (s) Level II is not indicated (comment if needed): _____

Based on a review of the referral **and/or consultation with referral source**, the person's case falls into one of the following categories:

- ☐ Diagnosis is not a major mental illness.
- ☐ No recent treatment.
- ☐ Does not meet level of impairment.
- ☐ Primary diagnosis of dementia (does not exclude for MR/related condition).
- ☐ History does not indicate MR and/or MR cannot be validated.
- ☐ Does not meet criteria for related condition.
- ☐ Change of condition does not effect nursing facility or specialized service needs.

PASRR EVALUATION COMPUTER SUMMARY

This form must be submitted for every Level II Evaluation billed to the DMHMRS and must be completed by evaluator.

**NOTE: ANSWER EACH QUESTION COMPLETELY.
CIRCLE ANSWERS OR FILL IN THE BLANKS WITH NUMBERS ONLY.**

DATE SUBMITTED TO DMHMRS: ____/____/____

REGION OF EVALUATOR: (Circle One) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

CLIENT IDENTIFYING NUMBER: _____ -- _____ -- _____

CLIENT NAME: (Please Print) _____

CLIENT BIRTHDATE: ____/____/____ **SEX:** M F

TYPE OF EVALUATION: (Circle One in Each Section)

Section 1

1. MI
2. MR
3. Dual

Section 2

1. Pre-Admission/Initial
-- New to Facility/PASRR Pre-Admission
-- Provisional/Initial
-- Exempted Hospital Discharge/Initial
2. Subsequent Review

TIMEFRAME:

PreAdmission/Initial/Subsequent Reviews

- a. Date of Referral: ____/____/____
- b. Date Verbal Given: ____/____/____
- c. Date Written Report Sent: ____/____/____

PASRR REFERRAL APPROPRIATE: (Circle One) Y N

If yes, continue on. If no, stop and circle Disposition #9.

RECOMMEND NURSING FACILITY PLACEMENT: (Circle One) Y N Region #: ____

REQUIRES SPECIALIZED SERVICES: (Circle One) Y N If yes, circle all below that apply:

Treatment Type

1. MI
2. MR

Treatment Site

1. Nursing Facility
2. Community/Other

Length of Stay in NF

1. More Than 30 Months
2. Less Than 30 Months

REQUIRES SERVICES OF LESSER INTENSITY THAN SPECIALIZED SERVICES: Y N

DISPOSITION: (Circle One)

1.	Admission To or Continued Stay in NF; No Specialized Services Recommended
2.	Admission To or Continued Stay in NF; With Specialized Services Recommended
3.	Admission To or Continued Stay in NF; With Specialized Services/Client Declined
4.	Not Admitted to NF or Does Not Need NF Care; Recommended to State Treatment Facility/CMHC Program
5.	Not Admitted to NF or Does Not Need NF Care; Recommended to Private Treatment Facility/Community Program
6.	Not Admitted to NF; No Action Taken
7.	Admission To or Continued Stay in State IMD
8.	Admit to Out-of-State Nursing Facility
9.	Inappropriate Referral/Meets Exemption/Process Stops, Dementia
10.	Deceased/Discharged from NF – Delete From System

INSTRUCTIONS FOR COMPLETING PASRR COMPUTER SUMMARY FORM

This form must be completed for every assessment, pre-admission, initial, or subsequent review.

Line 1:	<u>Date Submitted to DMHMRS:</u>	Enter date summary submitted to the Department.
Line 2:	<u>Region of Evaluator:</u>	Circle the appropriate number that identifies the community mental health center region where the evaluator is located.
Line 3:	<u>Client Identifying Number:</u>	Enter client social security or identification number.
Line 4:	<u>Client Name:</u>	Enter client name (last name first).
Line 5:	<u>Client Birthdate:</u>	Enter client birthdate and circle the appropriate letter to identify client's sex (M=male, F=female).
Line 6:	<u>Type of Evaluation:</u>	For <u>Section 1</u> , circle whether a person has a mental illness, mental retardation, or dual diagnosis.
		For <u>Section 2</u> , circle appropriate number.
		× 1. Pre-admission/initial (for all persons applying for admission to the nursing facility, or who were admitted under Provisional or Exempt hospital D/C status and are now due the first Level II, or individual s admitted to a nursing facility and the Level I did not trigger a Level II, but new information makes it necessary to have a Level II completed.)
		× 2. Subsequent review (for all persons who have had previous Level IIs, and have experienced a significant change in condition).
Line 7:	<u>Timeframe</u>	Pre-admissions/Initial/Subsequent Reviews
		a. enter the date the nursing facility made referral to Center for evaluation (by phone or written referral);

		b. Enter the date verbal determination was given to the nursing facility. This must be done within five (5) working days of referral;
		c. Enter the date written report was sent to the nursing facility, resident, and appropriate others as noted in Manual, Part III, Section 3.a. Timeframes are cited in Section 3.5.
NOTE:	If evaluations do not meet designated timeframes, please attach documentation addressing reason for non-compliance.	
Line 8:	<u>PASRR Referral Appropriate:</u>	Circle Y=Yes or N=No.
	This section was created to eliminate inappropriate referrals entering the PASRR data system. Only clients who triggered a "1" in Type of Evaluation , <u>Section 2</u> , may have a "No" answer to this question.	
Line 9:	<u>Nursing Facility Level of Care:</u>	If Line 8 is "Yes", circle appropriate letter related to facility level of care (Y=Yes or N=No). Also, place region number that identifies the Community Mental Health Center region where the client's nursing facility is located. Enter the number of the CMHC completing the evaluation if the client is going to a nursing home out-of-state.
Line 10:	<u>Requires Specialized Services:</u>	<p>Circle Y=Yes or N=No</p> <ul style="list-style-type: none"> ✕ if "Yes", circle whether specialized service was recommended for MI or MR AND ✕ Circle whether specialized service treatment site will be in NF or in the community (anywhere other than NF) AND ✕ Circle whether resident has been in the facility more than thirty (30) months or less than thirty (30) months.
Line 11:	<u>Requires Services on a Lesser Intensity than Specialized Services:</u>	Circle Y=Yes or N=No

<u>DISPOSITION:</u>		
Line 12:	Circle the appropriate number for disposition.	
	<u>Disposition 1:</u>	<p>This disposition should be circled if client</p> <ul style="list-style-type: none"> ✕ meets all criteria for admission to or continued stay in a nursing facility; and ✕ does not need specialized services.
	<u>Disposition 2:</u>	<p>This disposition should be circled if client</p> <ul style="list-style-type: none"> ✕ meets all criteria for admission to or continued stay in a nursing facility; ✕ requires specialized services; and ✕ will receive those services in the nursing facility.
	<u>Disposition 3:</u>	<p>This disposition should be circled if client</p> <ul style="list-style-type: none"> ✕ meets all criteria for admission to or continued stay in a nursing facility; ✕ requires specialized services, but ✕ client refuses to receive specialized services.
	<u>Disposition 4:</u>	<p>This disposition should be circled for a client who</p> <ul style="list-style-type: none"> ✕ may or may not need nursing facility level of care; but ✕ requires specialized services and is recommended for admission to a state treatment facility or CMHC program.

	<u>Disposition 5:</u>	<p>This disposition should be circled for a client who</p> <ul style="list-style-type: none"> ✕ does not need nursing facility care; and ✕ needs specialized services and prefers to go to a private treatment facility or can be treated in a community program.
	<u>Disposition 6:</u>	<p>This disposition should be circled for a client who</p> <ul style="list-style-type: none"> ✕ does not meet all criteria for admission to or continued stay in a nursing facility; and ✕ does not need specialized services.
	<u>Disposition 7:</u>	<p>This disposition should be circled if client</p> <ul style="list-style-type: none"> ✕ is in a psychiatric hospital applying for admission to IMD; or ✕ on-going resident reviews continuing to stay in IMD.
	<u>Disposition 8:</u>	<p>This disposition should be circled for a client who</p> <ul style="list-style-type: none"> ✕ is going to a facility out-of-state.
	<u>Disposition 9:</u>	<p>This disposition should be circled if client</p> <ul style="list-style-type: none"> ✕ is already in the system, but has dementia since last evaluation; ✕ is referred for a Level II and is determined not to have a serious mental illness or mental retardation/related condition; or ✕ does not meet criteria for nursing facility level of care; and/or ✕ is referred for a Level II and is determined to have dementia.

	<u>Disposition 10:</u>	<p>This disposition should be circled if client</p> <ul style="list-style-type: none">✕ is in the system; and✕ died since last evaluation; or✕ was discharged from the nursing facility since last evaluation.
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EXPLANATION OF PASRR BILLING

NOTE: Utilize this form to justify PASRR MI or MR evaluations that exceed a cost of \$500 or \$750 for dual diagnoses.

DATE OF REVIEW: ____/____/____

TYPE OF EVALUATION: ____Pre-admission ____Initial Review ____Subsequent Review

NAME OF CLIENT
(OPTIONAL): _____

SOCIAL SECURITY NUMBER: ____-____-____ UNITS: ____ RATE: COST: ____

Identify those categories that contributed to the billing of units. For each item checked, please provide an explanation for why more units than usual were needed for this evaluation.

- ☐ Travel Time

- ☐ Review of Records and Other Necessary Documents

- ☐ Compiling Data and Writing Report

- ☐ Utilization of More Than One Professional

- ☐ Collateral Contacts with Family or Significant Others

- ☐ Other

STAFF NAME: _____

REGION: _____ DATE: _____

PLEASE MAIL TO:

**DIVISION OF MENTAL HEALTH
100 FAIR OAKS LANE 4E-D
FRANKFORT, KY 40621-0001**

SPECIALIZED SERVICES IDENTIFICATION FORM (MI ONLY)

REGION: _____ DATE FORM COMPLETED: _____ / _____ / _____

Specialized services is defined as a continuous program over and above what the nursing facility can offer, which would *be comparable to services* which would be received in a psychiatric facility. More detailed definitions are included in the PASRR manual. Submit this form and a copy of the completed evaluation to the Division of Mental Health.

NAME: _____ AGE: _____

DIAGNOSIS: _____ DETERMINATION DATE: _____

NURSING FACILITY: _____

DESCRIBE THE SPECIALIZED SERVICES PLAN

SIGNATURE OF PERSON COMPLETING THIS FORM

DATE

PLACEMENT OPTION FORM

Name _____

SS # _____

Nursing Facility _____

As required by federal regulations, a Pre-admission Screening and Resident Review (PASRR identifies those long-term nursing facility residents with mental retardation who have been identified as being in need of specialized services (active treatment) for their mental retardation or related condition. Long-term is defined as thirty (30) months from the date it was first determined that nursing facility services were no longer needed and specialized services for mental retardation or related condition were needed. These persons have a choice of staying in the facility to have these services provided or moving to an alternate placement, either an Intermediate Care Facility/Mental Retardation (ICF/MR) or a Supports for Community Living Waiver Placement in the community. Specialized services for mental health do not take place in a NF; however, a resident who has had a Level II mental health evaluation and meets the 30-month criteria, shall not be subject to further level of care determinations.

Therefore:

I understand that as a long-term resident of a nursing facility, I have the option of staying and receiving services in the facility, or leaving and receiving specialized services (active treatment) in an alternate placement. These specialized services needs have been identified through the PASRR process and staff from the community mental health mental/retardation center have provided me with an explanation of my placement options. Additionally, as a resident of 30 months or more, there will be no further determinations regarding level of care.

- ☐ () I choose to remain in the nursing facility and receive specialized services there.
- ☐ () I choose to receive specialized services in a Supports for Community Living (SCL) Waiver Placement.
- ☐ () I choose to receive specialized services in an ICF/MR.
- ☐ () I chose another community placement and supports.
(specify choice) _____
- ☐ () I am a PASRR client who meets the 30-month requirement. No further determinations regarding level of care are necessary.

Signature of Client/Legal Representative

Witness

Date

Person Completing Form/Date

Medicaid Forms

Nursing facilities are responsible for completing, routing, and filing these forms. The forms are useful for PASRR evaluators to have on hand; however, they contain explanations for processes that evaluators are often asked to interpret and follow.

The MAP—409 (Level I) is used to determine whether criteria are present indicating the need for a completed Level II evaluation. It is supposed to be completed by nursing facility staff prior to admission to the facility. It is an invaluable tool for evaluators who make the *ultimate* determination of appropriateness for a Level II evaluation.

The MAP—4092 is the exempted hospital discharge form. Please note that the applicant's physician must sign that the applicant will require nursing facility care for thirty (30) days or less for continued treatment for the condition for which he/she received care in the hospital. This form should not be used to hasten hospital discharges when there is clearly not a thirty (30) day exception.

The MAP—4093 is the provisional admission form for cases of delirium and respite. On the form is an explanation of time frames for completing the Level II if this is required.

The MAP—4094 is used to notify families or responsible parties that the applicant or resident is being referred for a Level II evaluation.

The MAP—4095 is used to notify the PASRR office that there has been a significant change in the resident's condition that has the potential to affect his or her need for continued nursing facility stay or specialized services. It frequently is forwarded to PASRR offices as referral notification.

NOTE: These forms are “not original” Medicaid forms. They contain the same information as original forms, but have been retyped.

**COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
NURSING FACILITY IDENTIFICATION SCREEN (LEVEL I)**

Applicant Name – Last, First	Social Security Number	Date of Birth
Applicant's Address	City	State
	Zip Code	

- I. An individual is considered to have mental illness (MI) if he/she meets all of the following requirements regarding diagnosis; level of impairment and duration of illness.

A. DIAGNOSIS:

The individual has a major mental disorder [as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DMS—III)] which includes: a schizophrenic, mood, paranoid, panic, or other severe anxiety disorder; somatoform disorder; other psychotic disorders; or another mental disorder that may lead to a chronic disability. This does not include a primary diagnosis of dementia, including Alzheimers' disease or a related disorder, or a non-primary diagnosis is a major mental disorder as defined above. ____**Yes** ____**No**

B. LEVEL OF IMPAIRMENT:

The mental disorder resulted in functional limitations in major life activities within the past three (3) to six (6) months that would be appropriate for the individual's developmental stage. An individual typically has at least one (1) of the following characteristics on a continuing or intermittent basis (check the appropriate boxes):

☐ **1. Interpersonal functioning.** The individual has serious difficulty interacting appropriately and communicating effectively with other individuals, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships, and social isolation;

☐ **2. Concentration, persistence, and pace.** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks with an established time period, makes frequent errors, or requires assistance in the completion of these tasks;

☐ **3. Adaptation to change.** The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

C. RECENT TREATMENT:

The treatment history indicates that the individual has experienced at least one of the following (check the appropriate box(es)):

- ☐ 1. Psychiatric treatment more intensive than outpatient psychiatric care more than once in the past two (2) years (e.g. partial hospitalization or inpatient hospitalization); or

Name of inpatient facility, partial program, or other mental health treatment

- ☐ 2. Within the last two (2) years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing, or law enforcement officials.

- D. Does the applicant meet all of the requirements of having a mental illness listed in Section I. A-C? Yes No

II. Mental Retardation and Related Conditions

An individual is considered to have mental retardation if he/she has a level of retardation (mild, moderate, severe, or profound) as described in the American Association of Mental Retardation Manual on Classification in Mental Retardation (1983).

- A. The individual has significantly sub-average general intellectual functioning (I.Q. of approximately 70 or below) resulting in, or associated with, concurrent impairments in adaptive behavior and manifested during the development period, before the age of 18. Yes No

- B. Is there a history of mental retardation or developmental disability in the identified past? Yes No

- C. Is there any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or a developmental disability? Yes ☐ No ☐

Please List: _____

- D. Has the person been referred by an agency that serves persons with mental retardation or developmental disabilities and been deemed eligible for that agency services? Yes No

Please List Agency: _____

- E. “Persons with related conditions” means individuals who have a severe, chronic disability that meets **all** of the following conditions:

1. It is attributable to:
 - a. Cerebral palsy or epilepsy; or
 - b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for those persons.

MAP 409
Page Three

2. It is manifested before the person reaches age 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three (3) or more of the following:
 - a. Self care;
 - b. Understanding and the use of language;
 - c. Learning;
 - d. Mobility;
 - e. Self-direction; or
 - f. Capacity for independent living.

Examples of diagnoses that may indicate that the individual has a related condition if all the above criteria are met include:

Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida, Muscular Dystrophy, Orthopedic Impairment, Speech Impairment, Spinal Cord Injury, or Deafness/Blindness.

Does this applicant meet all of the conditions in Section E?

 Yes No

- III. If responses to the applicable Section I and/or Section II were answered "Yes", do not admit the applicant to the nursing facility. The nursing facility staff shall refer the applicant to the Community Mental Health Center for a Level II PASRR. The Level II PASRR determination shall be completed prior to the nursing facility admitting the applicant.

IF RESPONSES TO THE APPLICABLE SECTION I AND/OR SECTION II WERE ANSWERED "NO" AND THERE IS NO FURTHER EVIDENCE TO INDICATE THE POSSIBILITY OF MENTAL ILLNESS, MENTAL RETARDATION, OR OTHER RELATED CONDITION, THE NURSING FACILITY MUST DECIDE WHETHER OR NOT TO ADMIT THE APPLICANT. ADMISSION TO THE FACILITY DOES NOT CONSTITUTE APPROVAL FOR TITLE XIX LEVEL OF CARE.

- IV. **Does the applicant meet the Criteria for Exceptional Admission to a Nursing Facility without a Level II PASRR. The applicant may be admitted if one of the following conditions exists (PLEASE NOTE TIME LIMITS):**

A. Person Is An Exempted Hospital Discharge

Although identified as an individual with mental illness, mental retardation, or other related condition, an applicant who is not dangerous to self and/or others may be directly admitted for nursing facility services from an acute care hospital **for a period up to thirty (30) days** without a Level II PASRR if such admission is based on a written medically prescribed period of recovery for the conditions requiring hospitalization. An Exempted Hospital Discharge Physician Certification form shall be completed and in the resident's clinical record at the nursing facility.

 Yes No

B. Person Requires Respite Care

Although identified as an individual with mental illness, mental retardation, or other related condition, an applicant who is not dangerous to self or others may be admitted for Respite Care **for a period up to fourteen (14) days** without a Level II PASRR. A Provisional Admission Form shall be completed and in the resident's clinical record at the nursing facility. ☐ Yes ☐ No

C. Person Has A Diagnosis of Delirium

Although identified as an individual with mental illness, mental retardation, or other related condition, an applicant who is not dangerous to self and/or others may receive nursing facility services **for a period up to fourteen (14) days** without a Level II PASRR, if certified by the referring or attending physician to have a diagnosis of delirium. A Provisional Admission Form shall be completed and in the resident's clinical record at the nursing facility. ☐ Yes ☐ No

ROUTING OF FORM

This form shall be completed by nursing facility personnel prior to admission of the applicant to the nursing facility.

If the individual wishes to apply for Medicaid, application shall be made to the local county DSI office in the usual manner.

The facility is required to call the PRO for the Medicaid level of care determination prior to admission, and a copy of the Level I and, if appropriate, Level II PASRR, shall be faxed to the PRO. Except for the pre-admission screening process, the procedure of approval of nursing facility applicants remains the same.

A COPY OF THIS FORM, AS WELL AS A COPY OF THE LEVEL II PASRR DETERMINATION, IF REQUIRED, SHALL BE PLACED IN EACH RESIDENT'S CLINICAL RECORD AT THE FACILITY.

If someone other than the person signing the form provided any of the above history, please list name and telephone number:

I understand that this report may be relied upon for payment of claims from Federal and State funds. Any willful falsification or concealment of a material fact may result in prosecution under Federal and State Laws. I certify that to the best of my knowledge, the foregoing information is true, accurate, and complete.

Signature _____	Title _____	Date _____	Telephone Number _____
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Facility Name _____	Medicaid Provider Number _____
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COPY TO: **Original – Community Mental Health Center**
 Second – Medical Records

MAP—4092

**COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING (PAS)**

**EXEMPTED HOSPITAL DISCHARGE
PHYSICIAN CERTIFICATION OF NEED
FOR NURSING FACILITY SERVICES**

Applicant's Name _____

Social Security Number _____ Date of Birth _____

Name of Nursing Facility Requested _____ Date Admitted to NF _____

Nursing Facility Medicaid Provider Number _____

Name of Hospital Discharged From _____ Date of Discharge _____

Hospital's Medicaid Provider Number _____

Level I screen triggered mental illness ☐ YesLevel I screen triggered mental retardation or related condition ☐ Yes

Exempted Hospital Discharge: An exempted hospital discharge means:

1. The applicant is being admitted to a nursing facility after receiving acute inpatient care at the hospital; and ☐ Yes
2. The applicant requires nursing facility care for the condition for which he received care in the hospital; and ☐ Yes
3. The attending physician, upon signing this document, has certified to the nursing facility that applicant is likely to require less than thirty (30) days nursing facility services. ☐ Yes

Attending Physician Signature _____ Date _____

Print Attending Physician Name _____

Note: If an individual enters the nursing facility as an exempted hospital discharge and is later found to require more than thirty (30) days of nursing facility care, a Level II PASRR shall be completed within forty (40) calendar days of admission. The nursing facility staff shall refer persons with mental illness, mental retardation, or related condition for a Level II PASRR evaluation prior to the end of the exempt thirty (30) days by transmitting a copy of this form to the Community Mental Health/Mental Retardation Center. (This allows ten (10) calendar days for the Level II PASRR to be completed.)

Date Transmitted _____

Signature and Title _____

Print Name and Title _____

Original to Community Mental Health/Mental Retardation Center
Second Copy – Medical Records

MAP—4093

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING (PAS)

PROVISIONAL ADMISSION
TO A NURSING FACILITY

Applicant's Name _____

Social Security Number _____ Date of Birth _____

Name of Nursing Facility _____

Medicaid Provider Number _____ Phone Number _____

Address _____ Fax Number _____

Date Admitted to NF _____

Level I screen triggered mental illness ☐ Yes

Level I screen triggered mental retardation or related condition ☐ Yes

“Provisional Admission” means an individual who is admitted to a nursing facility for fourteen (14) days or less before a PASRR Level II is required; and

1. The applicant is expected to stay in NF for fourteen (14) days or less; and ☐ Yes
2. The applicant has been diagnosed with delirium; or ☐ Yes
3. The applicant is in need of respite for the in-home caregiver, and the applicant is expected to return to that in-home caregiver upon discharge from the nursing facility. ☐ Yes

Authorized Nursing Facility Staff _____ Date _____

NF Applicant Responsible Party _____

Note: If an individual who is admitted to a NF under the provisional admission is later found to require more than fourteen (14) days of nursing facility services, a Level II PASRR shall be completed within the fourteen (14) day provisional admission. Therefore, nursing facility staff shall refer the individual for a Level II PASRR as soon as it is indicated that the resident requires more than fourteen (14) days of nursing facility services by transmitting a copy of this form to the Community Mental Health/Mental Retardation Center. PASRR evaluators shall complete the Level II PASRR written evaluation report within nine (9) working days from the referral date.

Date Transmitted _____

Signature and Title _____

Print Name and Title _____

Original to Community Mental Health/Mental Retardation Center

Second Copy – Medical Records

MAP—4094

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

NOTIFICATION OF INTENT TO REFER
FOR LEVEL II PASRR

Individual/Resident Name _____

Social Security Number _____ Date of Birth _____

Home Address (if not in facility) _____

Name of Nursing Facility _____

Medicaid Provider Number _____

Facility Address _____ Phone Number _____

Date Admitted to Nursing Facility _____

Responsible Party _____

Address _____ Phone Number _____

Date Level I PASRR Completed _____

This is the written notification to inform the individual and the responsible party that the Level I PASRR indicates:

(Please check appropriate box)

a diagnosis of mental illness,
or mental retardation,
or a related condition.

☐
☐
☐

The individual is being referred to the Community Mental Health/Mental Retardation Center for a Level II PASRR. The Level II PASRR is an evaluation and determination of the need for nursing facility services, and if so, whether specialized services are needed.

Authorized Nursing Facility Staff _____ Date _____

Print Authorized Nursing Facility Staff Name _____

Original Copy to Individual or Responsible Party

Second Copy – Medical Records

Third Copy – Community Mental Health/Mental Retardation Center

MAP—4095

PASRR SIGNIFICANT CHANGE/DISCHARGE DATA**Resident Name:** _____**Date of Birth:** ____/____/____ **Social Security #:** _____**Facility:** _____ **ID#:** _____

“Significant change” means that the individual’s mental or physical condition has changed significantly in a manner that affects his/her need for specialized services or might no longer meet Medicaid criteria for nursing facility level of care. If any of the following events have occurred, please check the appropriate choice and forward this form to your local Community Mental Health/Mental Retardation within twenty-one (21) days. The Level II PASRR shall be completed within nine (9) working days upon receipt of this form.

Type of Change:

- ☐ Resident has a mental illness with active symptoms.
- ☐ Resident has a mental illness and the medical condition for which he/she was admitted has significantly improved.
- ☐ Resident has mental retardation or developmental disability and the medical condition for which he/she was admitted has significantly improved.
- ☐ Resident has mental retardation or developmental disability and now requires more intensive services than a nursing facility setting can provide.
- ☐ Resident has mental retardation or developmental disability and receives specialized services and medical condition has significantly declined.
- ☐ None of the above. No referral required.

Type of Discharge:

- ☐ Deceased
- ☐ Discharged: (Please check the appropriate discharge location)
1. ☐ NF Setting: ☐ KY ☐ Out of State
2. ☐ PC Setting 3. ☐ Supports for Community Living
4. ☐ Group Home 5. ☐ Foster Care Home
6. ☐ Other Community Setting (specify, if possible) _____

Signature of Facility Representative

____/____/____
Date

***Mail completed form to your Regional PASRR office.**

COVER LETTERS

The cover letters provided here are examples of what needs to be sent to the appropriate persons/entities designated by the manual when distributing evaluations and other information.

If these sample letters are utilized, please put them on your agency's letterhead.

Also, please customize the letters to convey only information concerning the individual in question.

Do not circle or underline one choice from multiple options.

Adverse Determination Appeals Letter (Initial)

(Date)

(Name, Address)

Dear _____:

Federal and state regulations (42 CFR 483.100, et seq and 907 KAR 1:755) require a Preadmission Screening and Resident Review ("PASRR") evaluation of each nursing facility applicant who has a history of mental retardation/developmental disability, or a serious mental illness, for the purpose of determining the need for nursing facility services and the need for specialized services for mental illness or mental retardation/developmental disability. Enclosed is a copy of this evaluation, along with an Interpretation of Findings form which requires your signature as verification that the evaluation and findings have been explained to you. Any questions you have regarding these findings or determinations should be forwarded to the person who signed this letter at your earliest convenience. Please note that your signature of the Interpretation of findings form does not imply agreement with these findings.

Based on the information we have reviewed that describes your physical and mental status, your nursing care needs, and your functional abilities, it has been determined that:

Your total needs do not require nursing facility placement. The criteria indicated by check mark below is the basis for this finding or determination.

() Your nursing care needs for which you have requested nursing facility admission result directly and specifically from a mental illness, mental retardation, or developmental disability as cited in 907 KAR 1:022, Section 4 (5), and are; therefore, excluded from coverage.

() You do not meet two (2) of the twelve (12) care needs categories set forth in 907 KAR 1:022 Section 4 and 907 KAR 1:755.

() the combinations of care needs for which you have requested nursing facility placement are beyond the capability of nursing facility provision under 907 KAR 1:022 Section 4 (5).

() You require in-patient psychiatric treatment.

If you require specialized services for mental retardation or developmental disability, some of these services may be identified in the evaluation. Specialized services for mental illness require the level of intensity provided in a psychiatric in-patient hospital.

This letter has been forwarded to you and/or your legal guardian. If you disagree with any of the above determinations, you have the right to appeal. All appeals shall be requested in writing and be postmarked within thirty (30) calendar days of the date of this letter and may be requested by you, your legal guardian, or authorized representative. **If your request for a hearing is postmarked or**

received within ten (10) days of the date of this letter, you may continue to stay in a nursing facility (if previously admitted) until the final cabinet level hearing. You may be represented at the hearing by yourself, a friend or relative, spokesperson, or other authorized representative, including legal counsel as specified in 907 KAR 1:563.

Send the request to: **The Division of Administration and Financial Management, Administrative Services Branch, Mail Stop 6W-C, 275 East Main Street, Frankfort, KY 40621.** Please preface your request for appeal by noting that denial or adverse determination was based upon PASRR findings or determination. Your request for a hearing will be acknowledged and will contain information regarding the date, time, and place that the hearing will be held.

Please contact me at () ____ - ____ if you have any questions regarding the evaluation or process.

Sincerely,

(Evaluator/PASRR Coordinator)

cc: Nursing Facility

Adverse Determination Appeals Letter (Subsequent)

(Date)

(Name, Address)

Dear _____:

Federal and state regulations (42 CFR 483.100, et seq and 907 KAR 1:755) require a subsequent PASRR evaluation must be performed due to a significant change in your condition since you were initially admitted to the nursing facility. Enclosed is a copy of this evaluation, along with an Interpretation of Findings form which requires your signature as verification that the evaluation and findings have been explained to you. Any questions you have regarding these findings or determinations should be forwarded to the person who signed this letter at your earliest convenience. Please note that your signature of the Interpretation of Findings form does not imply agreement with these findings.

Based on the information we have reviewed that describes your physical and mental status, your nursing care needs, and your functional abilities, it has been determined that:

Your total needs do not require nursing facility placement. The criteria indicated by check mark below is the basis for this finding or determination.

() Nursing facility is no longer the least restrictive environment where your needs can be met.

() Your nursing care needs now result directly and specifically from a mental illness, mental retardation, or developmental disability as cited in 907 KAR 1:022, Section 4 (5) and your total needs could be better met in a less restrictive environment.

() You no longer meet two (2) of the twelve (12) care need categories as set forth in 907 KAR 1:022 Section 4 and 907 KAR 1:755.

() You require in-patient psychiatric treatment.

If you require specialized services for mental retardation or developmental disability, some of these services may be identified in the evaluation. Specialized services for mental illness require the level of intensity provided in a psychiatric in-patient hospital.

This letter has been forwarded to you and/or your legal guardian. If you disagree with any of the above determinations, you have the right to appeal. All appeals shall be requested in writing and be postmarked within thirty (30) calendar days of the date of this letter and may be requested by you, your legal guardian, or authorized representative. **If your request for a hearing is postmarked or received within ten (10) days of the date of this letter, you may continue to stay in a nursing facility until the final cabinet level hearing.** You may be represented at the hearing by yourself, a

friend or relative, spokesperson or other authorized representative, including legal counsel as specified in 907 KAR 1:563.

Send the request to: **The Division of Administration and Financial Management, Administrative Services Branch, Mail Stop 6W-C, 275 East Main Street, Frankfort, KY 40621.** Please preface your request for appeal by noting that denial or adverse determination was based upon PASRR findings or determination. Your request for a hearing will be acknowledged and will contain information regard the date, time, and place that the hearing will be held.

Please contact me at () ____ - ____ if you have any questions regarding the evaluation or process.

Sincerely,

(Evaluator/PASRR Coordinator)

cc: Nursing Facility

Letter (Subsequent)

(Date)

(Name, Address)

Dear _____:

Federal and State regulations (42 CFR 483.100, et seq and 907 KAR 1:755) require a subsequent PASRR evaluation must be performed due to a significant change in your condition since you were initially admitted to the nursing facility. Enclosed is a copy of this evaluation, along with an Interpretation of Findings Form which requires your signature as verification that the evaluation and findings have been explained to you. Any questions you have regarding these findings or determinations should be forwarded to the person who signed this letter at your earliest convenience. Please note that your signature of the Interpretation of Findings Form does not imply agreement with these findings.

Based on the information we have reviewed that describes your physical and mental status, your nursing care needs, and your functional abilities, it has been determined that you meet nursing facility level of care as set forth in 907 KAR 1:022 Section 4 and 907 KAR 1:755 and may be readmitted or continue to reside in a nursing facility. You (do/do not) require specialized services for mental retardation or developmental disability.

If you require specialized services for mental retardation or developmental disability, some of these services may be identified in the evaluation. Specialized services for mental illness require the level of intensity provided in a psychiatric in-patient hospital.

Please contact me at (____) ____ - ____ if you have any questions regarding the evaluation process.

Sincerely,

(Evaluator/PASRR Coordinator)

cc: Nursing Facility

(Cover letter to be attached to copy of evaluation sent to nursing facility applicant/legal representative when applying to a nursing facility, as well as for an initial review, including hospital exemption, respite, delirium. For an applicant, keep in mind that if nursing facility care is not recommended, no further testing is necessary. Please modify this letter to fit the situation.)

(Date)

(Name, Address)

Dear _____:

Federal regulations require a preadmission evaluation of each nursing facility applicant who has a history of mental retardation or a serious mental illness, to determine the need for nursing facility services and the needs for specialized services for mental illness or mental retardation. Enclosed is a copy of this evaluation, along with an Interpretation of Findings form which requires your signature as verification that the evaluation and findings have been explained to you. This form must be returned to this center.

Based on the information we have reviewed describing your physical and mental status, your nursing care needs, and your functional abilities, we have made the following determinations:

- (1) You do require the level of serviced provided in a nursing facility; these needs cannot be provided in a less restrictive setting;
- (2) You [do/do not] require specialized services for 'mental illness/mental retardation].

If you require specialized services, a description of the services recommended is identified in the evaluation.

Please contact me at () ____ - _____, if you have any questions regarding the evaluation.

Sincerely,

(Evaluator/PASRR Coordinator)

cc: Nursing Facility

(Cover letter to be attached to copy of Review of Findings sent to attending physician and discharging hospital, if applicable, when applying to a nursing facility, as well as for an initial or subsequent review.

(Date)

(Name, Address)

Dear _____:

Federal regulations require a Preadmission Screening and Resident Review evaluation of each nursing facility applicant who has a history of mental retardation or a serious mental illness. Enclosed is a copy of the findings of the evaluation of (name of applicant/resident). Based on these findings, the following recommendations were made:

- (1) He/She [does/does not] require the level of care provided in a nursing facility; these needs cannot be provided in a less restrictive setting and he/she [may/may not] be admitted to a nursing facility.
- (2) He/She [does/does not] require specialized services (active treatment) for [mental illness/mental retardation].

If you have any questions regarding these findings, please contact me at () ____ - ____.

Sincerely,

(Evaluator/PASRR Coordinator)

cc: Nursing Facility